State of South Dakota
Division of Developmental Disabilities
Trend Analysis: 2012 Critical Incident Reporting
October 31, 2013

OVERVIEW

The Division of Developmental Disabilities (DDD) created an online reporting system for Critical Incident Reports (CIR) that was implemented on January 1, 2005. The system allows Community Support Providers (CSPs) to submit required reports electronically and allows the DDD to analyze data. The purpose of developing an online reporting system was to streamline the reporting process for CSPs. Implementation of this system coincides with the first day of the calendar year; therefore, CIR Annual Reports are issued according to the calendar year rather than the fiscal year.

The population covered by the CIR system includes all people receiving services funded through the DDD's CHOICES Waiver[1], Community Training Services (CTS) and private ICF/IID (Children's Care Hospital and School, CCHS). Policy Memorandum 11-02 stated that although the DDD does not have authority to require providers to report allegations of abuse, neglect, exploitation of non-division funded persons, it is good due diligence to report these allegations. Providers have obtained releases of information from these participants and/or their guardians who do not receive Home and Community Based Services (HCBS) or CTS. Providers began submitting these incidents in September 2010.

This is the eighth annual CIR report that provides a summary review of the data submitted by the nineteen CSPs and one private ICF/IID, aggregated for calendar year 2012. The DDD's intent is to issue a comprehensive trend analysis on an annual basis while providing provider-specific reports to each provider on a quarterly basis. The purpose of the report is to provide information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative and proactive initiatives. The DDD hopes that these reports will be helpful to administrators in support of their organization's continuous quality assurance and improvement systems, including managing their internal incident reporting system and comparing their data with statewide aggregate information.

Included in this document is a data analysis of all CIRs for all providers for 2012 including:

- Total number of persons supported by CHOICES waiver, CTS funding, and private ICF/IID funding;
- Total number of incident reports submitted;

[1] CHOICES is the name of the Division of Developmental Disabilities' Home and Community Based Services Comprehensive Waiver. It is an acronym for Community, Hope, Opportunity, Independence, Careers, Empowerment, Success. In this report, the term HCBS will be used to reference the CHOICES waiver program.

- A breakdown of reports by category; and
- Information regarding the total statewide number of incidents by category.

The process for managing the CIR system is a joint collaboration between the DDD and each of South Dakota's CSPs. Each CSP is commended for fulfilling the responsibilities related to CIR notification to the DDD, submission of CIRs, and responsiveness to the DDD's requests for follow-up.

The DDD Program Specialists are each assigned a CSP and are responsible for reviewing all CIRs submitted by that CSP. DDD nurses review all CIRs that involve health, medication, injury, unplanned hospitalizations or medication issues. The DDD also has a CIR/QA team that coordinates a peer review process for all CIRs. The peer review process is designed as a quality assurance mechanism to ensure that all necessary follow-up is completed, timelines are met, and that any additional third party reporting (e.g., to the Attorney General's Medicaid Fraud Control Unit, law enforcement, Department of Social Services) has occurred. The peer review process has increased the DDD's ability to address CIR inconsistencies both internally and systemically.

The CIR team also collects quarterly data and reviews trends by provider and CIR category. A root cause analysis process is used to determine areas of concern that might benefit from changes in policy and practice. A root cause analysis is a process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence of a sentinel event. As trends are identified, DDD Program Specialists are responsible for addressing issues with their assigned provider.

SYSTEMS IMPROVEMENTS IN 2012

1. CIR/QA Team has implemented the practice of reviewing all mortality reports on a monthly and quarterly basis to ensure accuracy in reporting as well as appropriate action taken to identify trends per provider and system-wide. If warranted, incident information will be forwarded to a South Dakota Developmental Center Physician's Assistant for review;
2. CIR/QA Team identified the need for additional selections in the online reporting form under Illegal Activity Type, Injury Type, and Injury Cause based on the high number of incidents categorized as Other in these areas and appropriate selections have been added;
3. CIR/QA Team assessed and streamlined the process for quarterly incident review and subsequent follow up with the provider by the Program Specialist;
4. CIR/QA Team completed a query of all pending incident reports from 2005 through 2011-those online incident reports that had been completed in part or fully, but not submitted to DDD. The CIR/QA Team then evaluated which of the pending CIRs continued to meet reporting requirements and asked providers to submit the reports to ensure due diligence of waiver assurances;
5. Additional data reports have been created through the CIR online reporting system, including breakdown for each provider for location of incident, cause of injury, type of altercation, and suspected of abuse, neglect, and exploitation

(ANE). The additional reports further assist DDD in identifying trends by provider as well as system-wide;
6. DDD Program Specialists training includes an initial orientation, updates and issues are continually addressed during staff meetings to ensure increased consistency in reviewing CIRs;
7. The CIR/QA Team continually analyzes data collection processes within DDD in order to ensure that data collection is efficient and consistent on a monthly, quarterly, and annual basis;
8. The CIR/QA Team continues to evaluate the current process for assigning peer reviews and quarterly reviews. This process ensures that reviews occur in a timely fashion, consistently, and that follow-up occurs by the Program Specialist as well as the CSP.

REGULATORY AUTHORITY

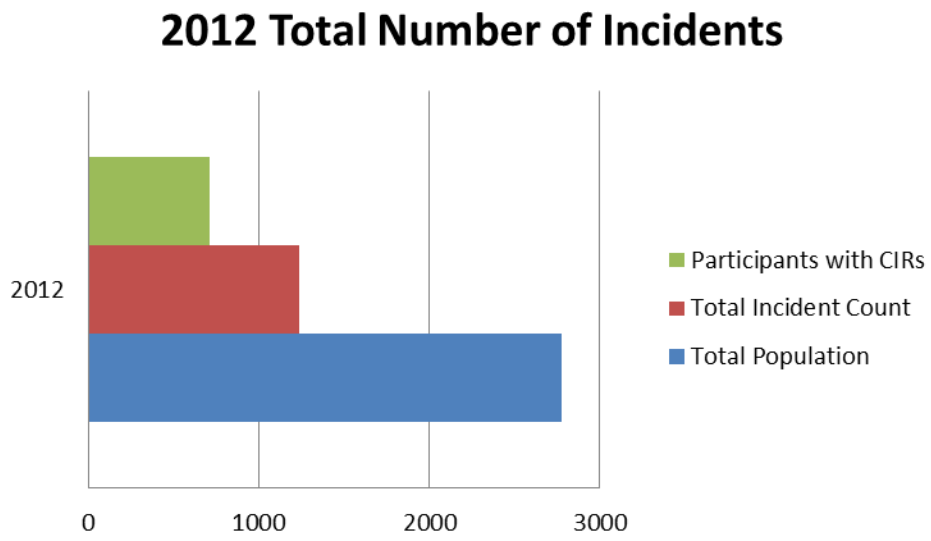
The authority behind the submission of incident reports is as follows:

Administrative Rule 46:11:03:02. Incident reports – submission to the Division.
The ATC must submit an incident report and the form, DHS-DD-708, furnished by the Division for any unusual accident or injury involving a consumer receiving services. The ATC shall give verbal notice or a facsimile of the incident to the Division within 48 hours or the next working day, whichever occurs first, once the ATC becomes aware of the incident. The ATC shall submit a written incident report to the Division within seven calendar days after the verbal notice. A report must be submitted in the following instances:

1. Death;
2. Life-threatening illnesses or injuries, whether hospitalization occurs or not;
3. Alleged instances of abuse, neglect, or exploitation against or by consumers;
4. Changes in health or behavior that may jeopardize continued services;
5. Serious medication errors;
6. Illness or injuries that resulted from unsafe or unsanitary conditions; and
7. Any illegal activity that involves a consumer;
8. Any use of physical, mechanical, or chemical intervention, not part of an approved plan;
9. Any bruise or injury resulting from the use of a physical, mechanical, or chemical interventions; or
10. Any reportable communicable disease involving a participant.

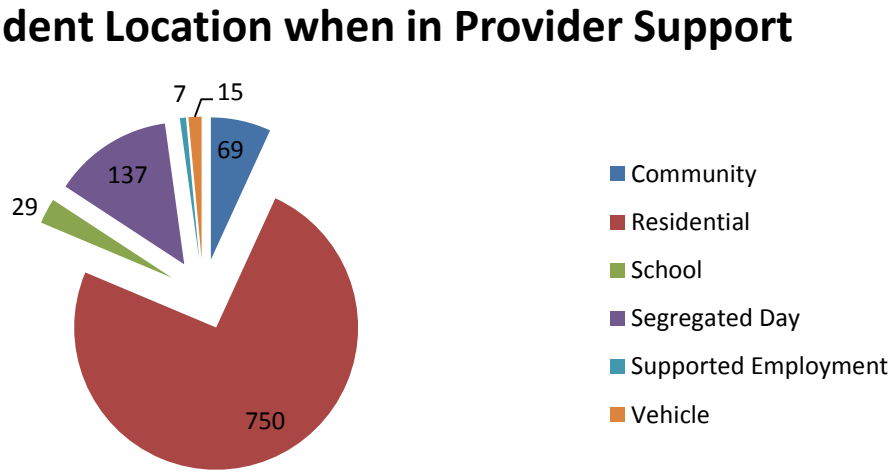
An online CIR reporting system replaced form DHS-DD-708 in 2005[2].

[2] It should be noted that some incident category narratives and graphs do not date back to 2005, as some categories were not originally included in the online reporting system.

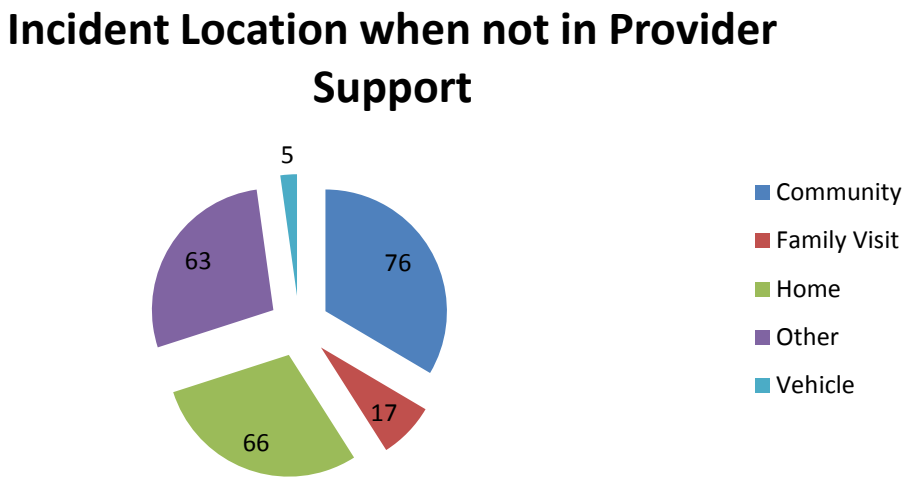


In 2012, the number of persons supported through HCBS, CTS and Private ICF/MR funding increased by 69, and the number of participants for whom Critical Incidents were reported also increased by 13 participants from 2011.

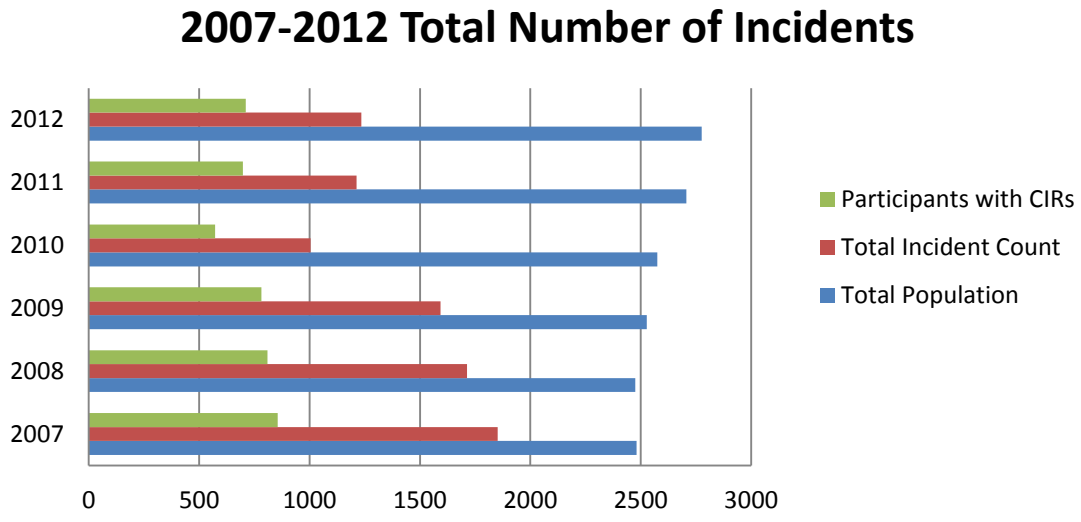
The total incident count for 2012 was 1,234, an increase of 21 incidents from the previous year. These incidents were submitted for 711 participants, or 56.6% of all participants in South Dakota receiving supports and services through CHOICES, CTS or CCHS.



While receiving provider support, incidents primarily occur at residential settings and segregated day settings. Participants are likely spending most of their time in these environments, as 750 incidents occurred in residential settings and 137 incidents occurred in segregated day settings. Significantly less incidents occur while participants are at other locations in the community, supported employment, school, and in vehicles. The data may also indicate that incidents are less likely to occur when participants are partaking in activities outside the home and segregated work settings.



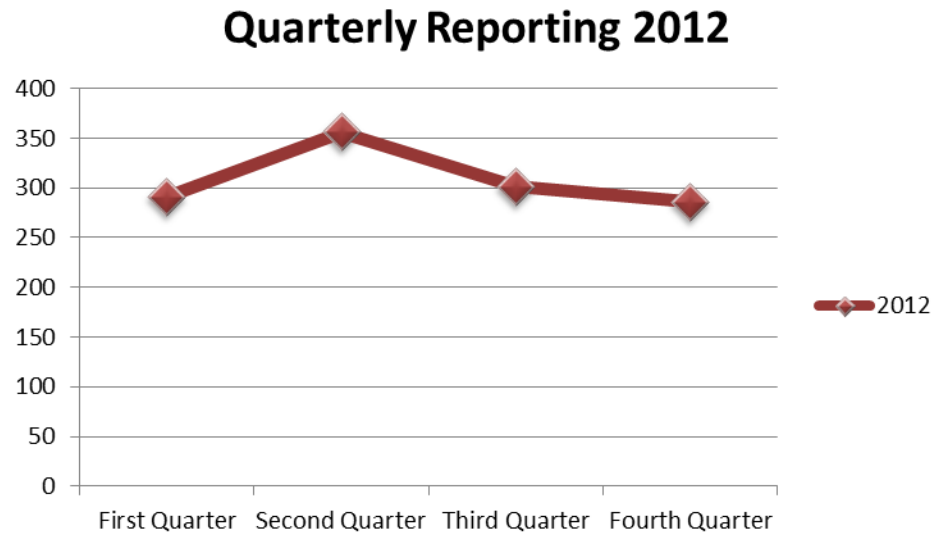
Incidents that occur while people are outside of provider support happen most frequently in the "community" with 76 reports. This may mean that participants are accessing the community by themselves or with natural support networks and includes a variety of locations. Sixty-six incidents occurred while people were at home, which encompasses participants who reside in a supported living environment and receive minimal residential supports as well as participants who live in a home with family members. Sixty-three incidents occurred at "other" locations, which include, but are not limited to, clinics, hospitals, and local events/businesses.



	Total Population	Total Incident Count	Participants with CIRs	% of Participants with CIRs
2007	2481	1852	855	34.46%
2008	2475	1714	809	47.20%
2009	2528	1594	782	49.06%
2010	2575	1004	572	56.97%
2011	2707	1213	698	57.54%
2012	2776	1234	711	57.62%

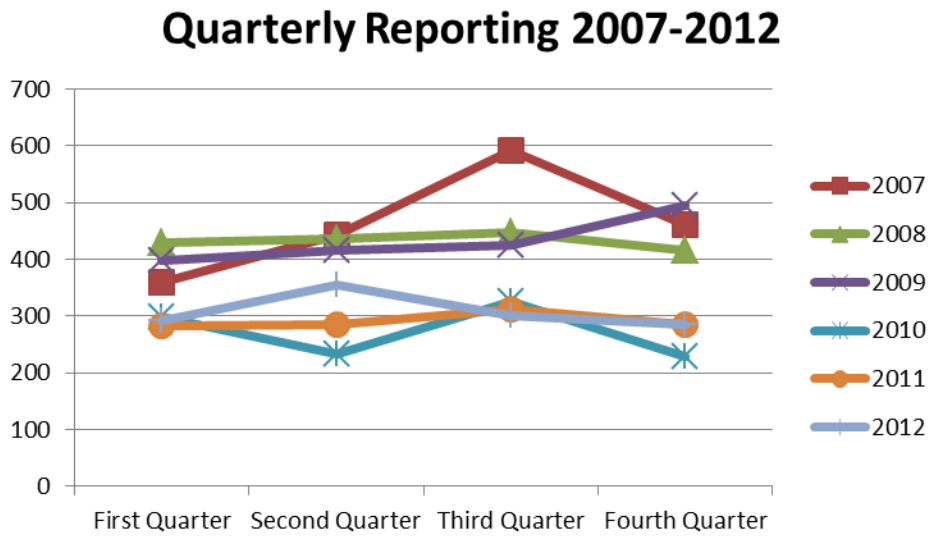
The total population of participants supported in South Dakota has grown on average by 49 participants since 2007. The total population has increased overall in the past five years with the exception of 2008. Although there was a slight increase in incidents in 2012, this may be contributed to the fact that the number of participants has increased.

The table above reflects the fluctuation in population, incident count, and number of participants for whom CIRs were reported. The difference in the number of total incidents versus the number of participants is due to the fact that several CIRs may be submitted for the same participant throughout the year. The column "% of Participants with CIRs" is calculated by dividing the number of participants with CIRs by the total number of participants.



Quarterly Reporting 2012	
1st Quarter	291
2nd Quarter	356
3rd Quarter	301
4th Quarter	286

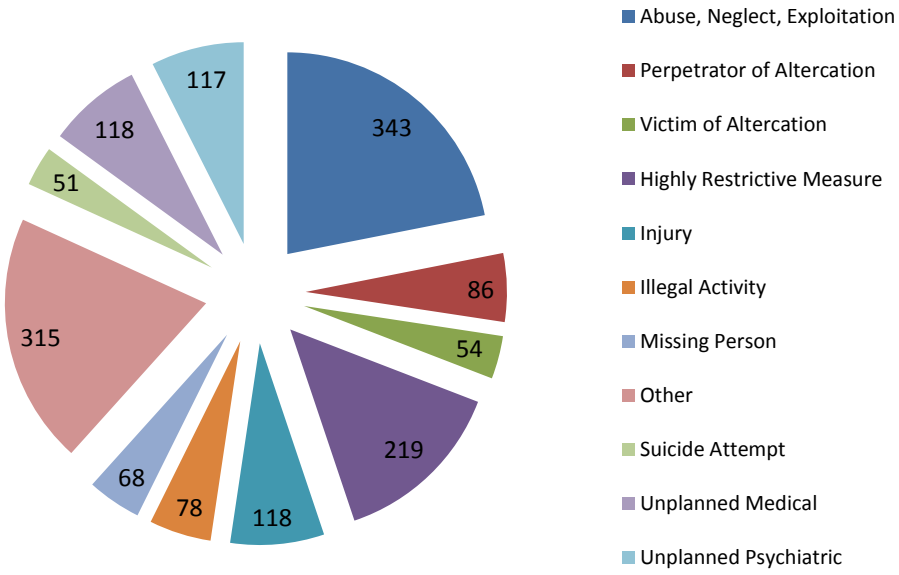
In 2012, quarterly reporting increased during the second quarter, (April 1 through June 30) which is not consistent with previous years' data. After further analysis it was determined that there are no trends identified regarding specific categories of critical incidents being reported within the third quarter.



	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
2007	360	442	592	462
2008	429	436	448	416
2009	397	416	424	496
2010	298	234	326	229
2011	282	285	313	284
2012	291	356	301	286

Since 2007, quarterly incident trends have remained fairly constant, with incident numbers increasing in the second and third quarters. An exception occurred in 2009 when incidents numbers spiked in the fourth quarter. There was also a decrease in reporting during the second quarter of 2010, which is uncharacteristic of other years' reporting.

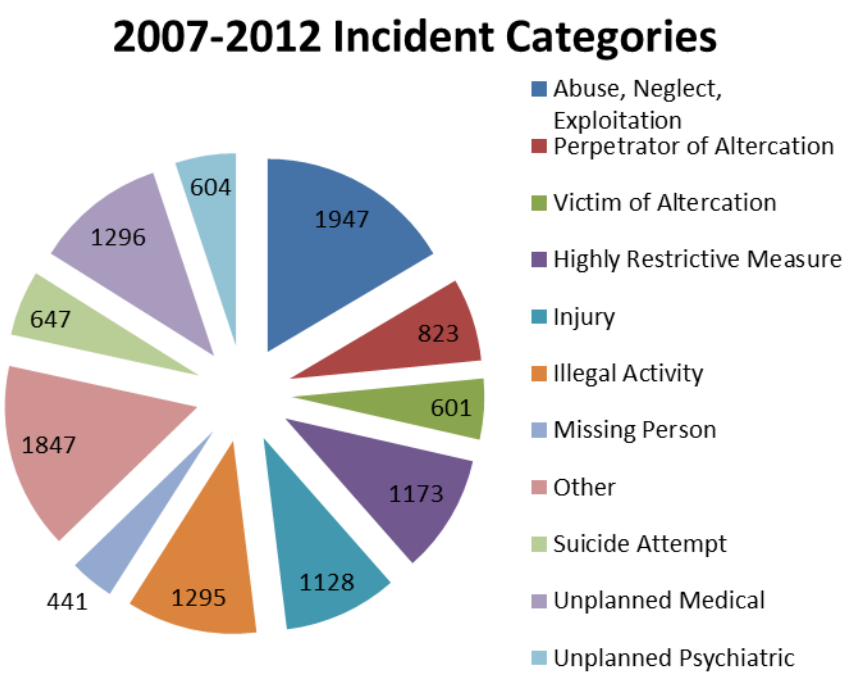
2012 Incident Categories



In 2012, the Critical Incident Reporting category most frequently reported to DDD was ANE with 343 incidents. This is an increase from 334 reports in 2011. The second highest category reported was the Other category, with 315 incidents. Twenty-one incidents within the Other category were categorized incorrectly. The Other incident category includes:

- Community Complaint;
- Increase in Behavioral Issues;
- Jeopardizing Personal Safety;
- Jeopardizing Services;
- Medical Diagnosis;
- Medication Error;
- Use of Illegal Substances;
- Vehicle Accident;
- Victim of Fire;
- Victim of Theft; and
- Communicable Disease.

Highly Restrictive Measures was the third most frequently reported with 219 incidents, followed by Injury and Unplanned Medical with 118, and Unplanned Psychiatric with 117. The category with the lowest number of incidents reported to the DDD was Suicide Attempt with 50 reports. The incident category reporting follows the same pattern as 2011, although Highly Restrictive Measures and Suicide Attempt reporting increased in 2012.



Incident reporting trends for 2007 through 2012 are consistent with 2012 reporting with ANE and Other being the most frequently reported incidents over the past six years. ANE reporting has ranged from 217 reports in 2010 to 400 reports in 2007, with an average of 325 incidents per year. A decrease of 89 incidents was noted in 2010, but incidents in this category increased by 126 incidents in 2011 and remained the same in 2012.

Incidents in the Other category total 1,847 from 2007 through 2012. Reporting in this category gradually decreased since 2007; however reporting has increased slightly within the last two years. This is the result of three providers with a significant (fifteen incidents or more) increase in reporting incidents in 2012.

Incident reporting in the remaining categories is as follows:

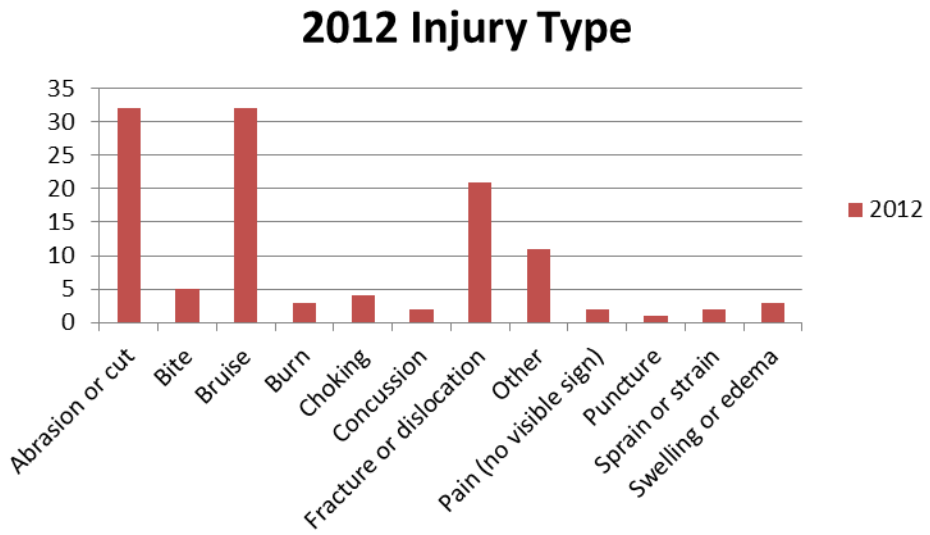
- Illegal Activity: A total of 1,295 incidents have been submitted since 2007. A significant decrease in reporting of illegal activity occurred in 2010, which corresponds directly to the change in reporting guidelines that required law enforcement involvement for the incident to warrant a CIR. In 2009 there were 348 reports of illegal activity, in 2010 there were 45 incidents, in 2011 there were 75 incidents and in 2012 there were 78 reports. The DDD requires that any illegal activity that involves a participant in which there is law enforcement involvement, including, but not limited to, arrests, incarceration, criminal court appearances/changes, and illegal drug use be reported as a CIR.
- Unplanned Medical: Any unplanned hospitalization that results from a life threatening illness or injury is reportable to the DDD. A total of 1,296 incidents have been reported since 2007, and like several other categories a significant

decrease in reporting occurred in 2010. This is due to the change in guidelines that requires a hospitalization to be life-threatening in nature to justify a CIR. In 2009 there were 281 reports submitted, 142 reports in 2010, 137 reports in 2011 and 118 reported in 2012.

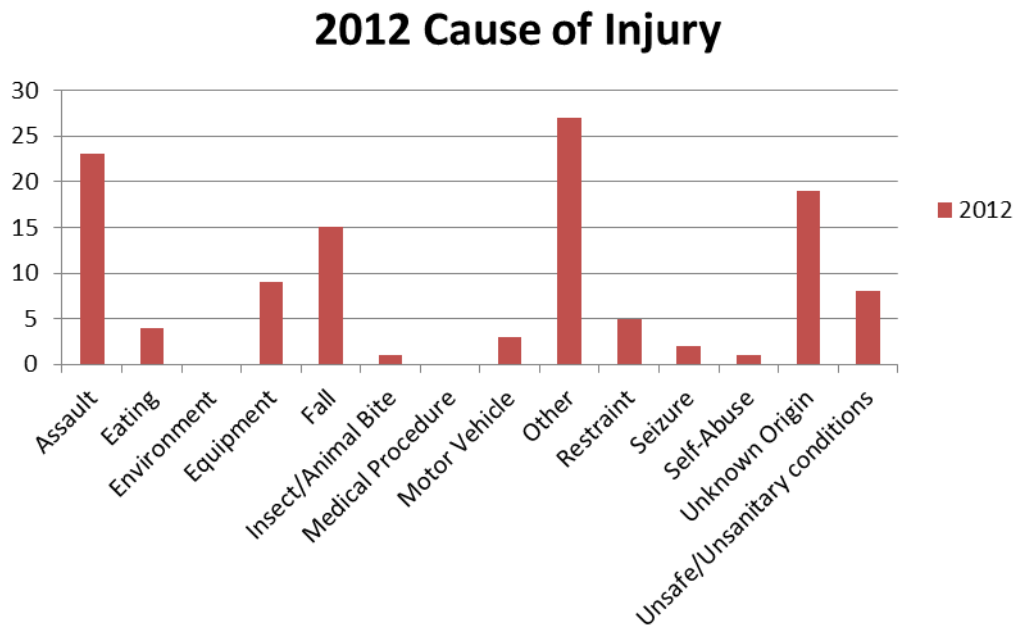
- Injury: A total of 1,128 injury reports have been submitted since 2007. Reporting trends for injuries has gradually decreased since implementation of the CIR reporting system. In 2011, reports of injuries increased by nineteen incidents from 2010. In 2012, reporting of injuries decreased by 40 incidents, totaling 118 reports. Injuries reportable to the DDD include those that are classified as "severe" which means that medical attention beyond first aid was required to treat the injury.
- Highly Restrictive Measures: Reporting of highly restrictive measures has remained fairly consistent since 2007, with the largest variation in reporting occurring between 2010 and 2011, with an increase of 46 incidents. This increase may be attributed in part to three providers showing an increase of ten or more incidents in 2011. Highly Restrictive Measures utilized that are not part of an approved plan are reported to the DDD. This includes restrictive measures that are not implemented as written and approved. Several providers have employed policies that prohibit any type of highly restrictive measure to be written into plans, which results in these providers reporting any restrictive procedure utilized to ensure health and safety of participants. A total of 1,173 reports have been submitted since 2007.
- Alleged Perpetrator of Altercation: Since 2007, 823 incidents have been submitted within this category. Reporting has decreased each year since 2007 with the exception of 2011. In 2010, 61 incidents were reported, a decrease of 59 incidents from the previous year; however reporting increased by 45 incidents in 2011. In 2012, the number of reports again decreased by 20, with total reporting of 86 incidents. These decreases may be due to Critical Incident Reporting training provided in December 2009 and December 2011. The DDD requires reporting of altercations that result in severe injury to the victim, which is defined in the CIR Guidelines. Altercations may also be reported if the incident coincides with a participant's increase in behavioral issues or with services being in jeopardy.
- Suicide Attempt: From 2007 through 2012, 647 incidents have been submitted within the suicide category. Annual reporting of suicide threats/attempts decreased dramatically in 2010, when CIR guidelines were revised to eliminate the reporting of threats made without a plan or means to follow through. Thirty-one incidents were reported in both 2010 and 2011. In 2012, 51 incidents were reported for 32 participants. Thirteen of the twenty providers reported suicide incidents in 2012, ten of those reports were rendered for one participant. That participant was discharged from the provider and admitted to SDDC.
- Victim of Altercation: In the past six years, 601 incidents have been submitted regarding victims of altercation. In 2007, the incident count was 186, with the next highest year of reporting being 2008 with 113 incidents. Since 2008, reporting in this category has tapered, with 54 incidents reported in 2012. Victim

of Altercation reports are submitted when a participant requires medical attention as a result of an altercation.

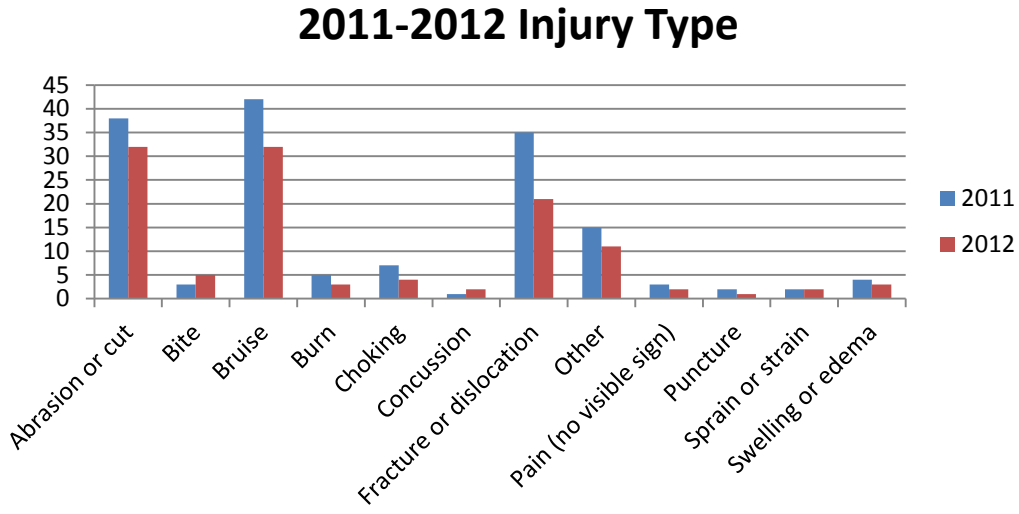
- Unplanned Psychiatric: The DDD requires any unplanned inpatient psychiatric hospitalizations be reported per CIR Guidelines. In 2012, providers reported 117 incidents of unplanned psychiatric hospitalization. This is an increase of 39 incidents since 2011; however, increased reporting from three providers accounted for 30 of the 39 incidents. Over the past six years, a total of 604 incidents have been submitted.
- Missing Person: Reported incidents of missing persons have remained relatively stable over the past six years, with the greatest variation being an increase of sixteen reports between 2009 and 2010. All other years within this timeframe reflect a difference of ten or less incidents, with the total number of reports since 2007 being 441. Missing person reports are submitted to DDD when a participant is on an unauthorized absence and at risk of harm to self or others. If the person has a protocol or a plan that addresses unauthorized absences, a report is not necessary unless the plan is not implemented as written.

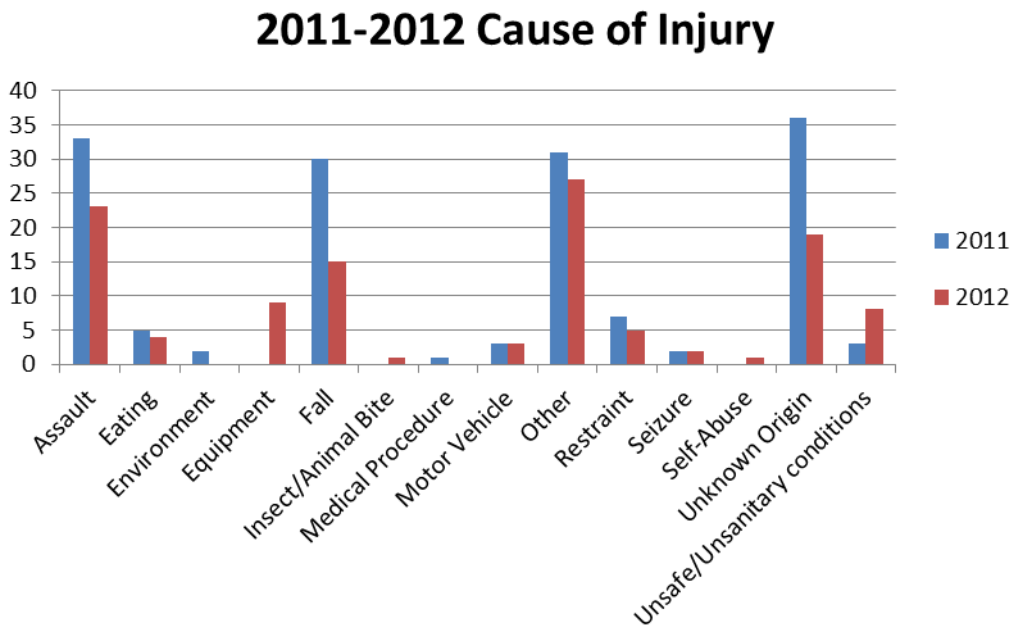


In 2012 there were 118 injuries reported to DDD. The most frequently reported injuries are abrasion/cut (32), bruise (32) and fractures or dislocations (21). Each of the other types of injuries had eleven or less reported incidents. These types of injuries include but are not limited to choking, concussion, bites, and burns. There were eleven "other" types of injuries reported to the DDD. Four of these reports were incorrectly categorized. Each of the four reports should have been categorized under other applicable categories: burn, abrasion, fracture and pain (no visible sign).

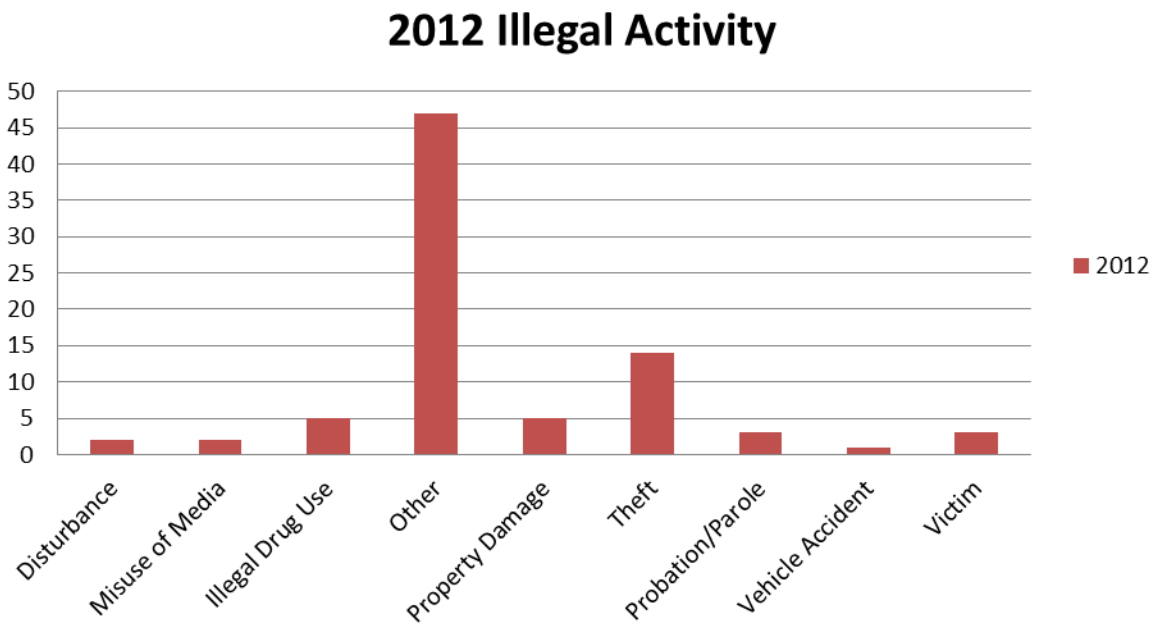


Cause of injury data reflects injuries of Other as the most frequently reported cause of injury reported to the DDD, with 27 reports in 2012. Other top causes of injury are Assault (23), Unknown Origin (19) and Falls (15). This information seems to correlate with the leading types of injuries which are bruises, abrasion/cut, and fracture/dislocation. Twenty-seven incidents captured as Other within cause of injury were reviewed by the DDD. Through this review, it was determined that 18 of these were captured as "Other-Self Inflicted" and would have been more appropriately categorized as Self-Abuse as the cause of injury.



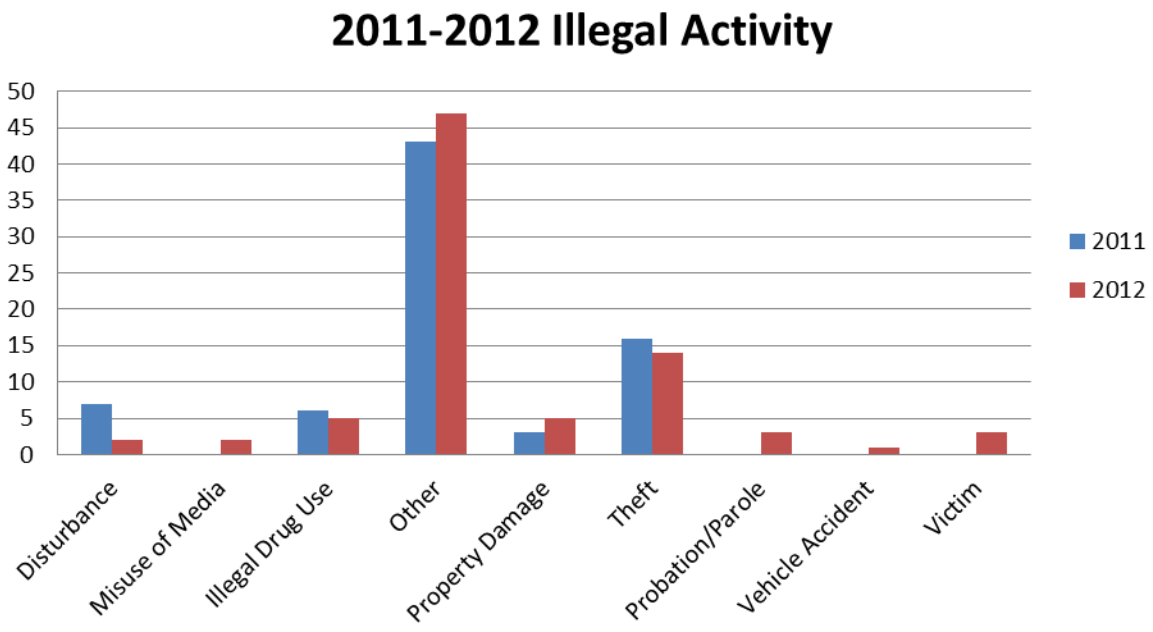


In 2012 there was a decrease of forty incidents relating to Injury reports. The leading causes and types of injuries have remained consistent since 2011. An overall decrease of forty incidents reported within the injury category resulted in a decrease in abrasion/cut, fracture/dislocation and bruise which are the most frequently reported types of injuries. In 2011, DDD reviewed the causes of injury listed as "Other". Commonalities discovered have been added to the online reporting form within this category including self-abuse.



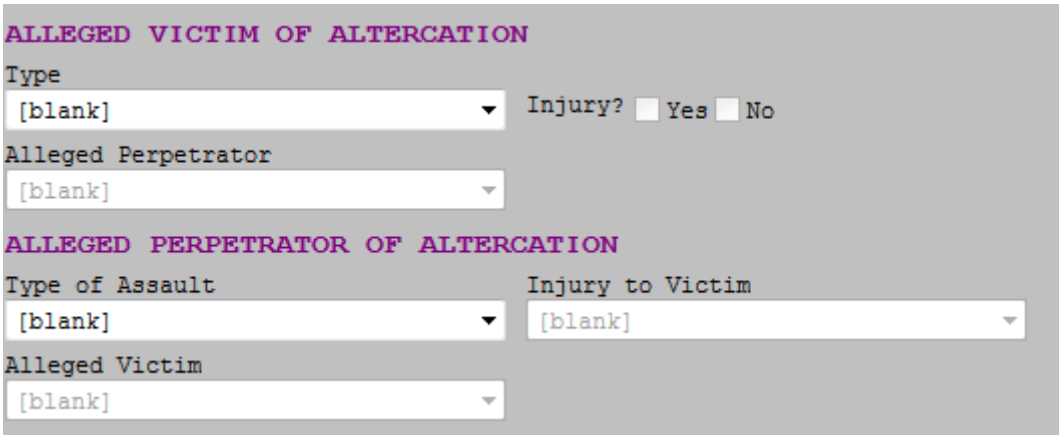
In 2012, the CIR team contacted providers regarding pending Critical Incident Reports from previous years. These incidents occurred and were entered as far back as 2006 via the previous CIR online reporting form. Data gathered for the 2012 annual report is based on the incident submission date rather than the date the incident occurred. Due to this, incident fields from years prior to 2010 are captured in 2012 data, where the fields no longer exist; therefore, "Victim" is noted on the graph for 2012 Illegal Activity due to having previously been listed within Law Enforcement Involvement. Until 2010, the CIR online reporting form captured Law Enforcement Involvement and Property Damage in separate categories. In 2010, categories within the reporting form were changed, with Illegal Activity as a general category, under which property damage and various other types of illegal activity were listed.

During an analysis of the 2012 data regarding incidents reported as illegal activity "other" it was determined that there weren't enough similarities in reported illegal activity to create new categories which would indicate a need for additional drop down options within this reporting category. Some of the "other" incidents were related to contributing to a minor, possible child abuse, housing minors, false reporting to the police and trespassing.

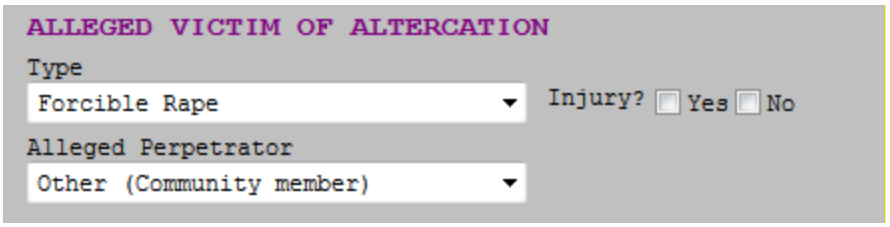


Illegal Activity incidents reported in 2012 totaled 82; with 47 of these reports being identified under the category of Other. Incidents identified as "other" have been assessed by the CIR team to determine if there are any commonalities. Commonalities discovered were added to the online reporting form within this category in December 2012.

ALLEGED VICTIMS/PERPETRATORS OF ALTERCATION:

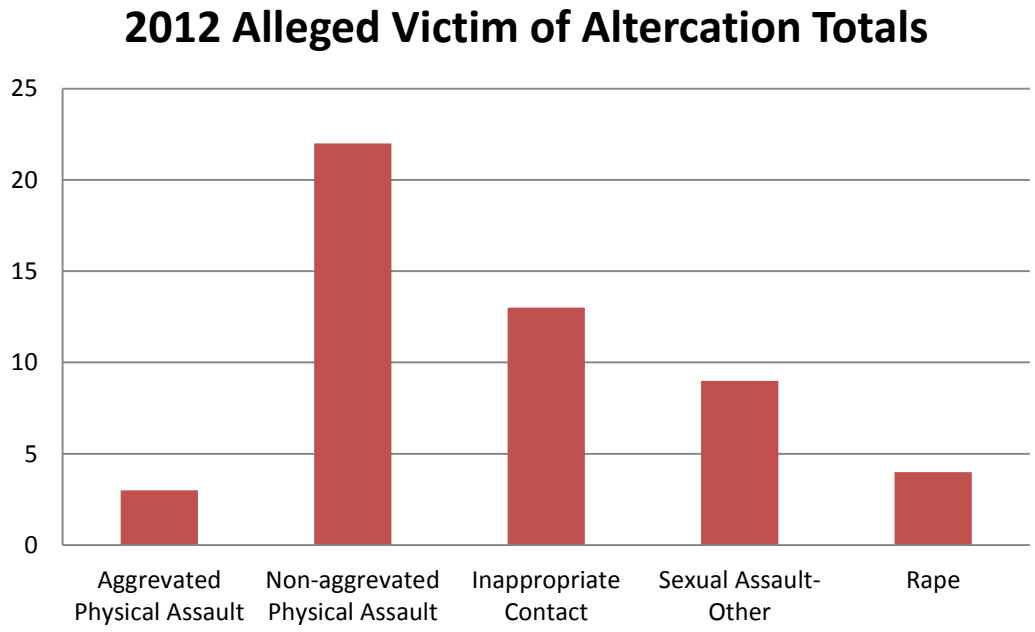


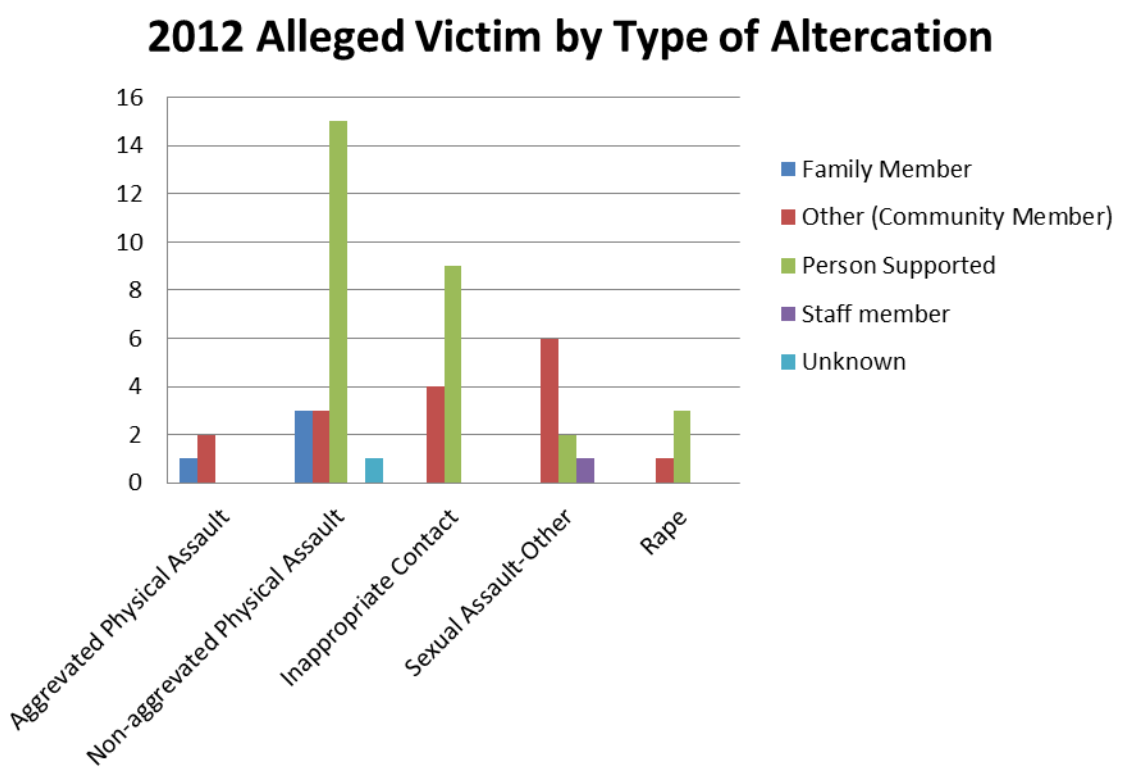
In 2011, the DDD began analyzing additional data regarding altercations specifically to identify trends in victims, perpetrators and types of altercations. As seen above, the data is generated from the Altercation section of the CIR form based on what is selected in the Alleged Victim or Perpetrator and Type of Assault dropdown boxes. DDD continues to analyze the data.



For example, the graph below shows four victims of Rape in 2012. This data was collected from the dropdown boxes as shown above. Of all alleged victim reports in 2012, three were categorized as aggravated physical assault, 22 were categorized as non-aggravated assault, 13 were inappropriate contact, four were classified as rape, and nine were sexual assault-other.

Data compiled for the four incidents of rape show that all three allegations were unsubstantiated. Local police departments were involved in three of the incidents and appropriate follow up occurred by the provider and Program Specialist for all of the incidents.

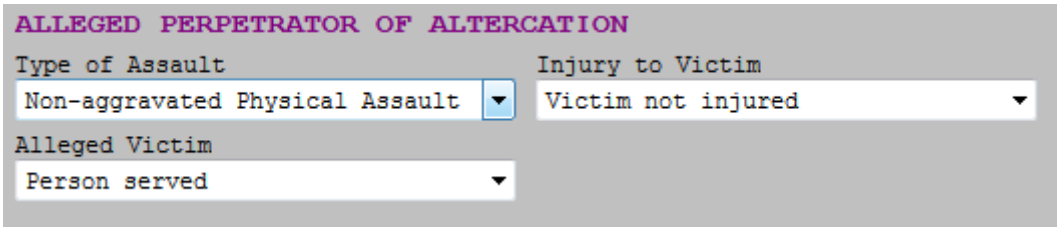




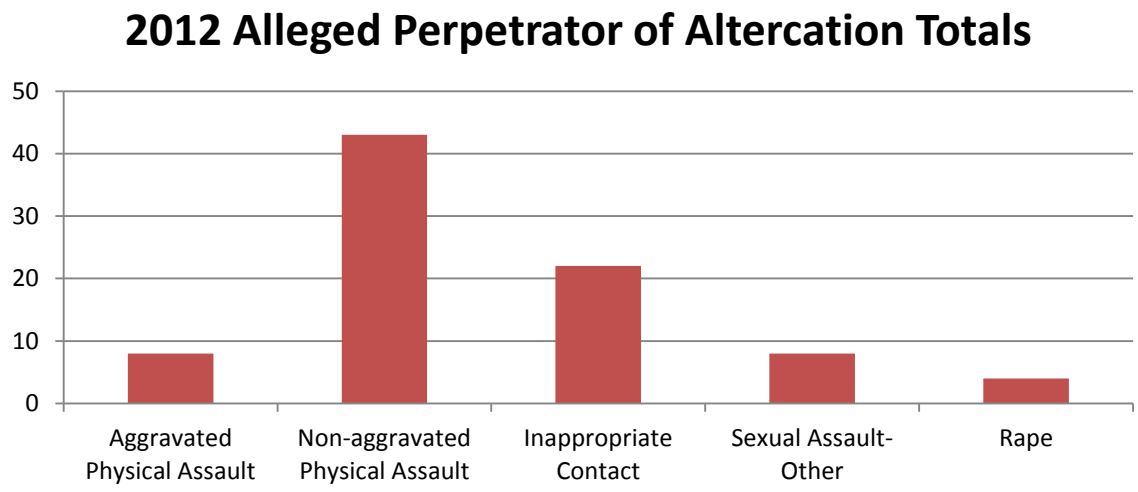
The report above demonstrates who perpetrators were for each type of altercation under the Alleged Victim section of the online CIR form. The graph indicates that there was one incident in which a staff member was accused of sexual assault-other against a participant. This was a CIR that was submitted in 2012 but occurred in 2009. The allegation was unsubstantiated.

The most frequently reported types of altercations are incidents in which one participant is assaulting another participant. This relates to the data indicating that incidents happen most frequently in residential and segregated settings where participants are in close proximity to each other. Non-aggravated assault and inappropriate contact incidents were reported most frequently, with twenty-two reports and thirteen reports, respectively.

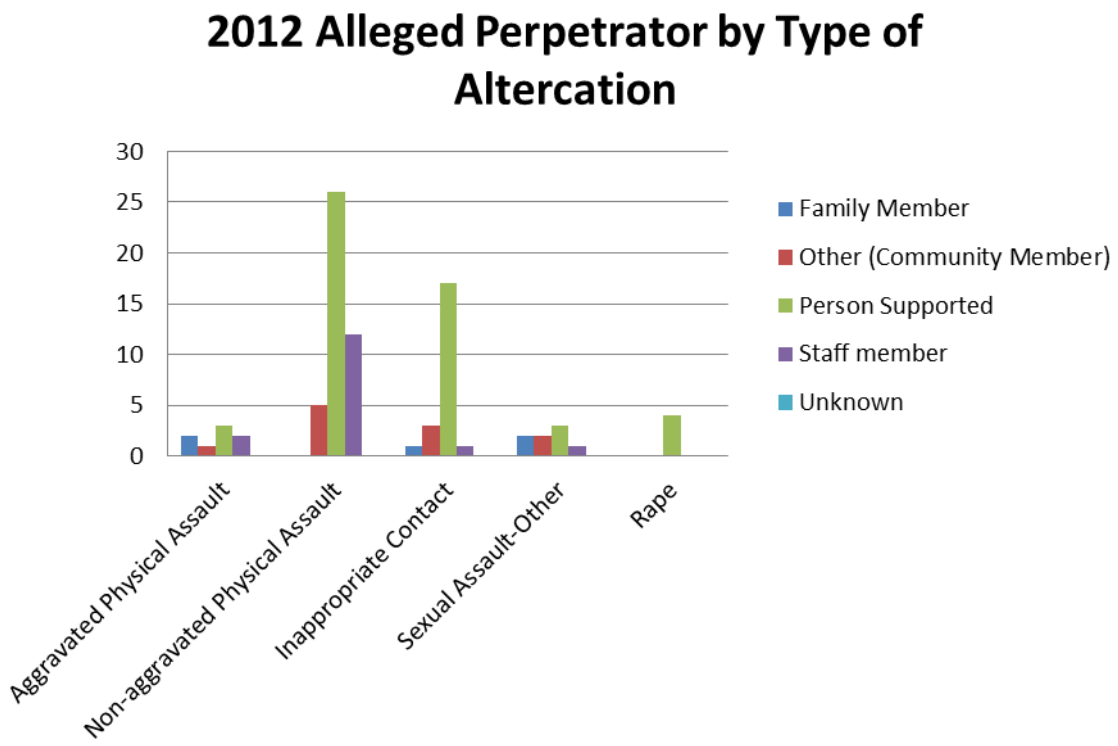
ALLEGED PERPETRATORS/VICTIMS OF ALTERCATION:



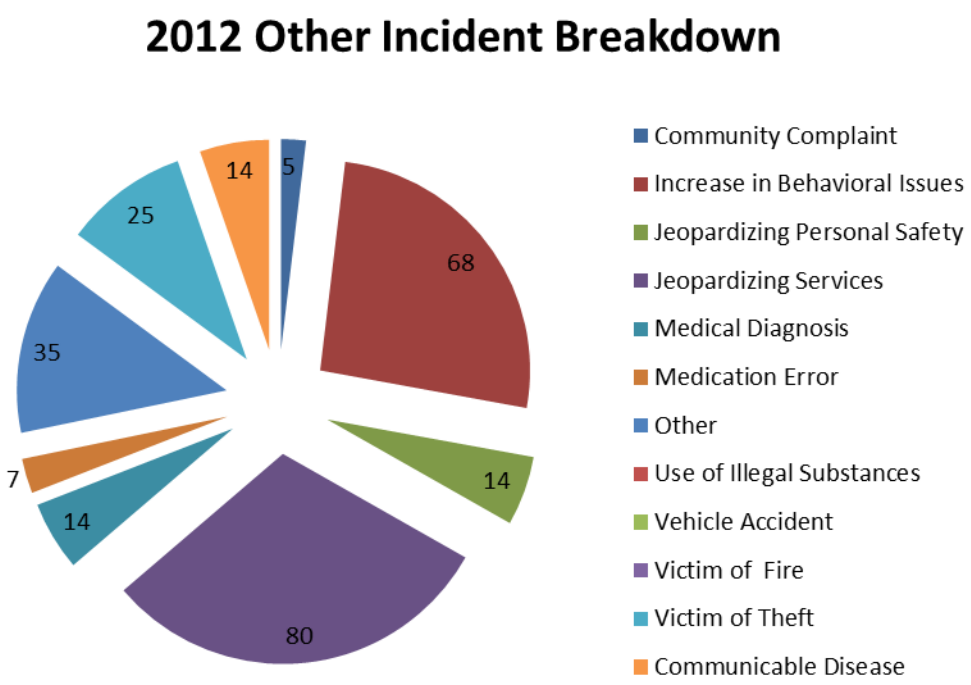
Data in the graphs below is generated from the CIR online report as shown above. The information indicates that there were 44 incidents in which a participant was the alleged perpetrator of non-aggravated physical assault, 18 incidents of inappropriate contact allegations, eight aggravated physical assault allegations and sexual assault-other allegations, and four incidents where participants were accused of rape.



The number of altercations reported in 2012 in which a participant was the perpetrator of an altercation is reflected in the graph above. The total number of reports in this area is considerably higher than the number of reports submitted in which a participant was the victim. This is likely due to more reports being made when participants display aggressive behaviors towards others, but in which the victim may not have sustained injury therefore no CIR was required for the victim.



The report above demonstrates who the victims were for each type of altercation under the Alleged Perpetrator section of the online CIR form. Reports for people supported are the highest in each of the categories. The second most frequently reported victim group is staff. The two most frequently reported types of altercations are non-aggravated physical assault and inappropriate contact. Again, incidents are likely to happen where people spend most of their time and those whom they spend most time with are likely to be victims.



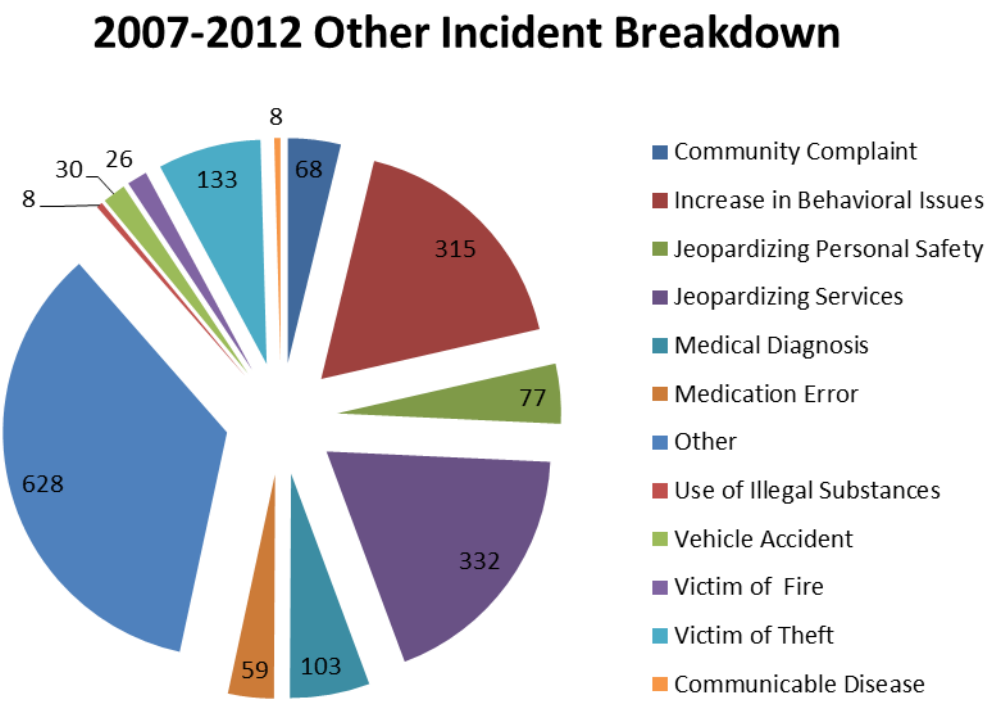
There are total of 262 CIRs that fell into the "Other" incident category during 2012. These included various reports, ranging from communicable disease to victim of theft. Of the total number, 80 incidents were reported due to services in jeopardy, 68 incidents due to an increase in behavioral issues, 25 were victim of theft, and 14 reports for communicable disease, jeopardizing personal safety and medical diagnosis. Thirty-five of these reports are unique and do not align with any single category. Some examples of these CIRs are:

- Change in health
- Choking incident
- Missing medications
- Vehicle accident
- Receiving harassing phone calls
- Reports related to evictions from their residence

Upon review of the unique reports it is clear that some were categorized incorrectly. Of the 35 reports in the "other" category that did not align with any single category, 21 should have been tracked in another category. This is an increase from 2011 when 14 incidents were incorrectly captured within the "other" category. The CIR workgroup will provide follow up and technical assistance to those providers which have incorrectly categorized incidents, as well as with DDD staff to ensure consistency in reviewing incidents.

It should also be noted that reporting in 2012 within Increase in Behavioral Issues decreased by three incidents from the previous year. However, reporting within Jeopardizing Services accounted for 85 incidents which is an increase from 38 reports from 2011. Review of the Jeopardizing Services incidents revealed that four providers

had an increase in this category of four or more incidents, eight providers increased reporting between one to three incidents, and eight providers reported the same number or less incidents than 2011. In 2012, eighty-five Jeopardizing Services CIRs were reported for 66 participants. At least ten people for whom a Jeopardizing Services CIR was submitted were discharged from services, and at least an additional eight transferred to SDDC.

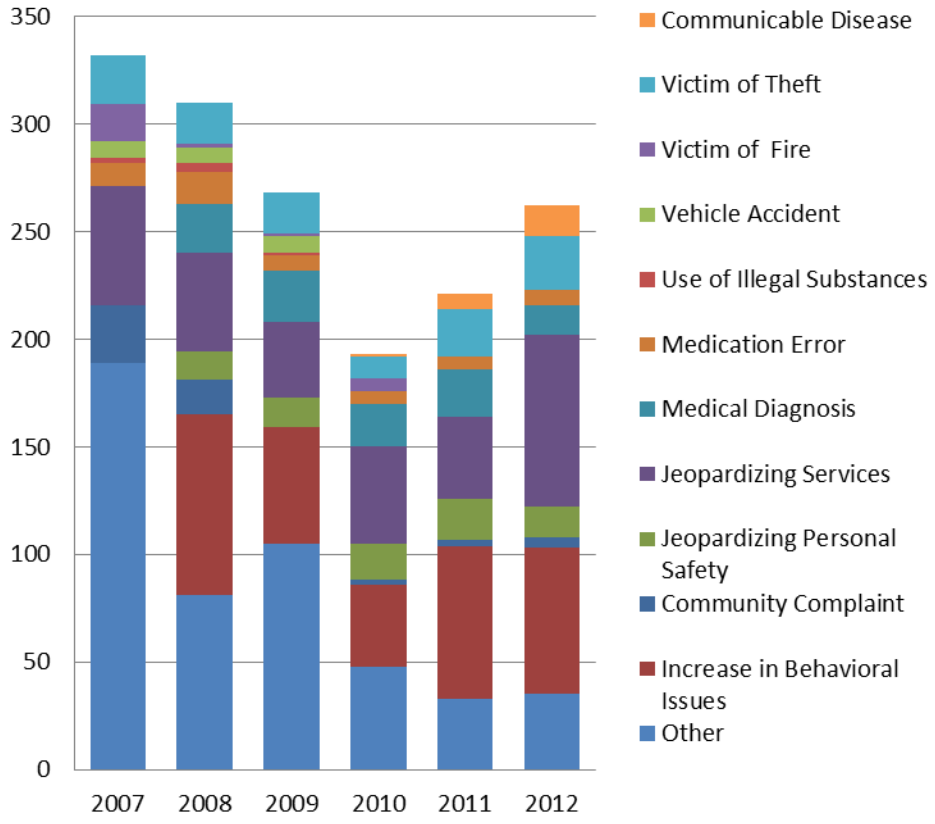


From 2007 through 2012, reports in the Other category totaled 1,787. A majority of these incidents (628) were categorized as Other-Other. The second most frequently reported category is Jeopardizing Services (332), followed by Increase in Behavioral Issues (315). 2012 data shows a slightly lower rate of "Other-Other" which indicates that Program Specialists have increased scrutiny of incident categorization.

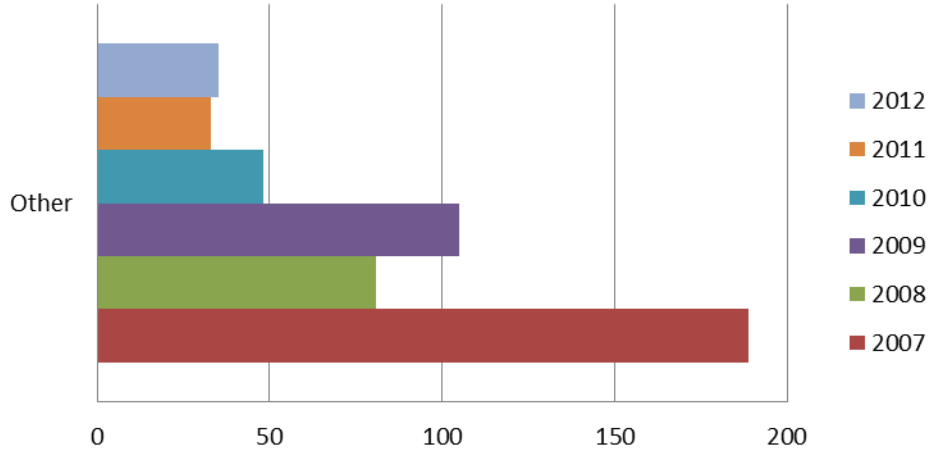
The graph above demonstrates the differences in reporting under Other from 2007-2012. It is evident that when the Critical Incident Reporting Guidelines and online reporting form were developed, most incidents were being reported as Other-Other. As DDD and CSP staff became better informed and other options were made available within the online reporting form, incidents were categorized more accurately.

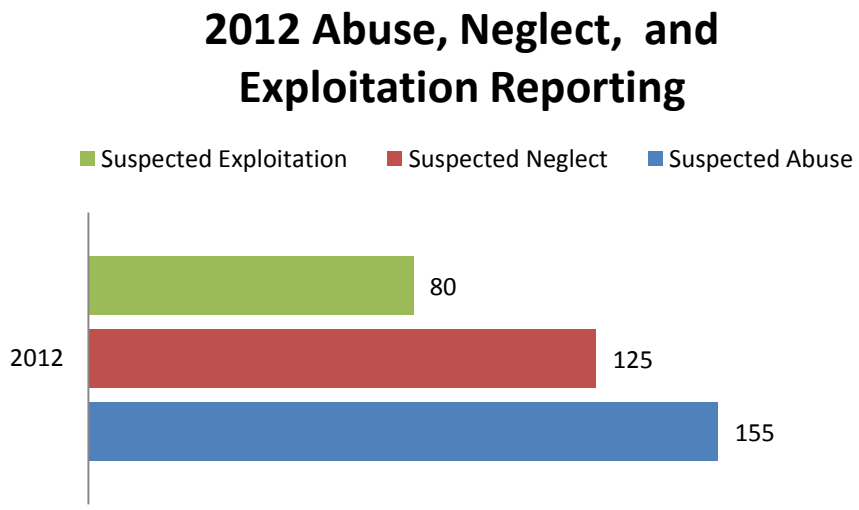
The graph below reflects the fluctuations in reporting under the Other-Other category. Between 2007 and 2012, the number of Other-Other incidents decreased, with the exception of 2009 with a slight increase in 2012. DDD continues to monitor and provide training to CSPs regarding categorization of incidents.

2007-2012 Other Incident Breakdown

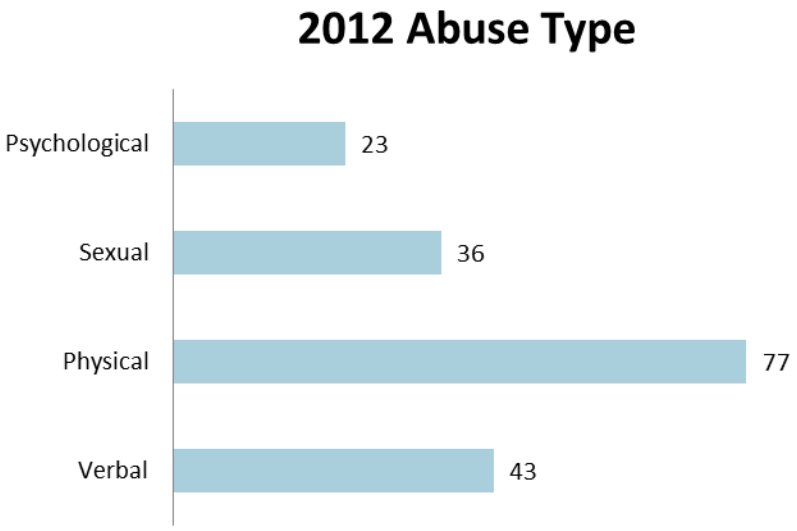


2007-2012 Other-Other Reporting



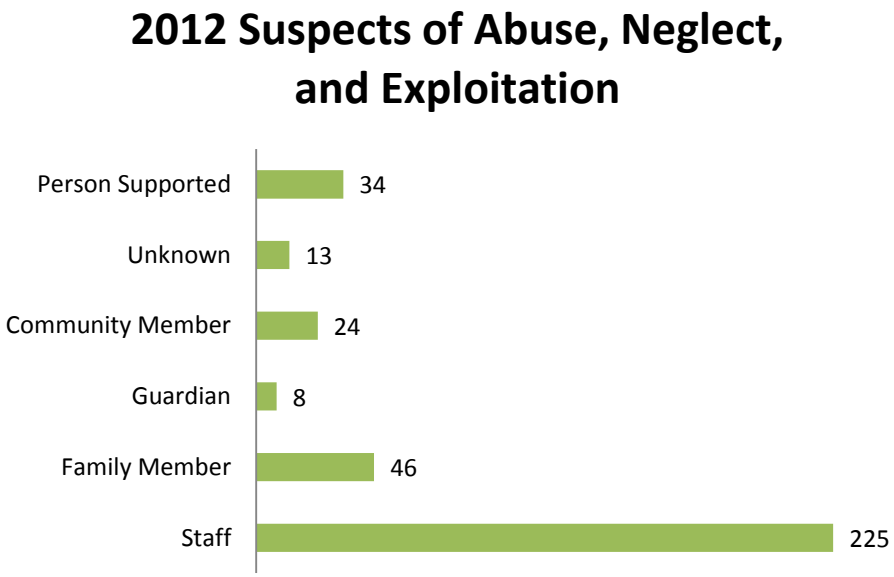


Incident reporting in the ANE category for 2012 was as follows: 155 abuse allegations, 125 neglect allegations, and 80 exploitation allegations. Suspected abuse has historically been more frequently reported than neglect and exploitation. Within the Critical Incident Report form, reporters are required to specify whether the abuse was verbal, physical, psychological, or sexual, which is reflected in the graph below. It is noted that the total number of verbal, physical, sexual and psychological allegations equal 360, whereas 155 allegations of abuse incidents were submitted. This is due to providers having the option to choose more than one type of alleged abuse within a single incident form.

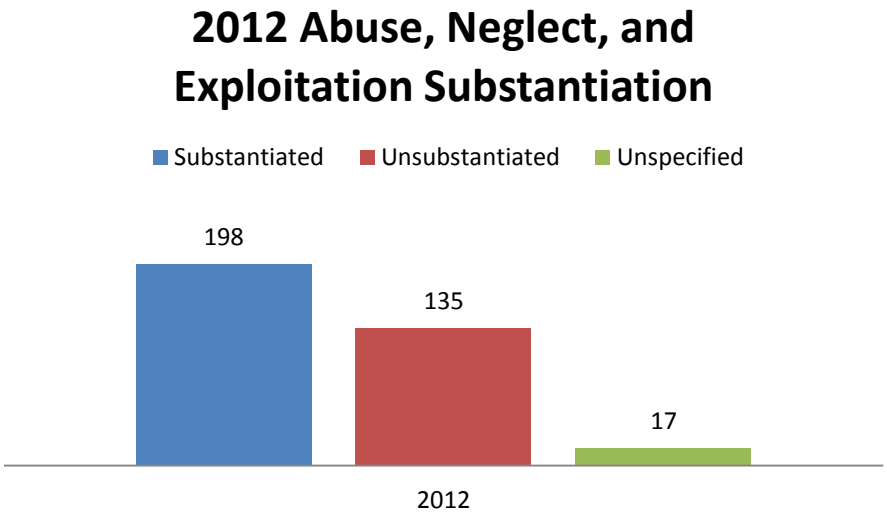


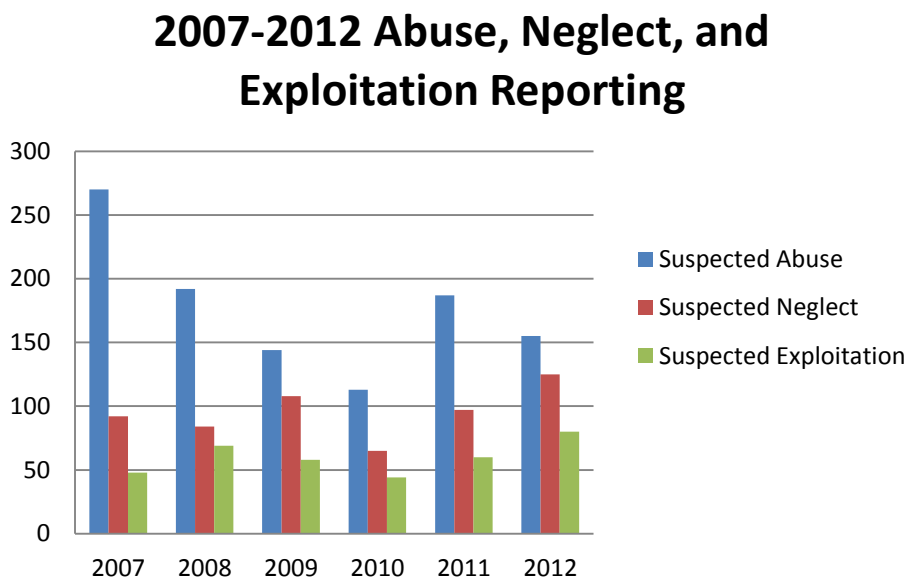
As the graph above indicates, the number of allegations of physical abuse is substantially higher than other types of abuse at 77 allegations, followed by allegations of verbal abuse at 43 reports. Sexual and psychological allegations are the lowest at 36 and 23 reports, respectively.

In the graph below a total of 360 ANE allegations were made in 2012. Of those, 225 were against staff members; 46 allegations were against family members; 34 were against other participants using supports; 24 were against community members; 13 were unknown; and 8 allegations were made against guardians.



In the graph below there is a total of the 360 ANE reports in 2012, 198 were substantiated, 135 were unsubstantiated and 17 were unspecified. Unspecified is an indication that the Program Specialist marked neither the substantiated nor the unsubstantiated section while reviewing the CIR online report. Follow up will occur with Program Specialists to ensure incidents are accurately categorized. The data shows a 55% substantiation rate among providers.



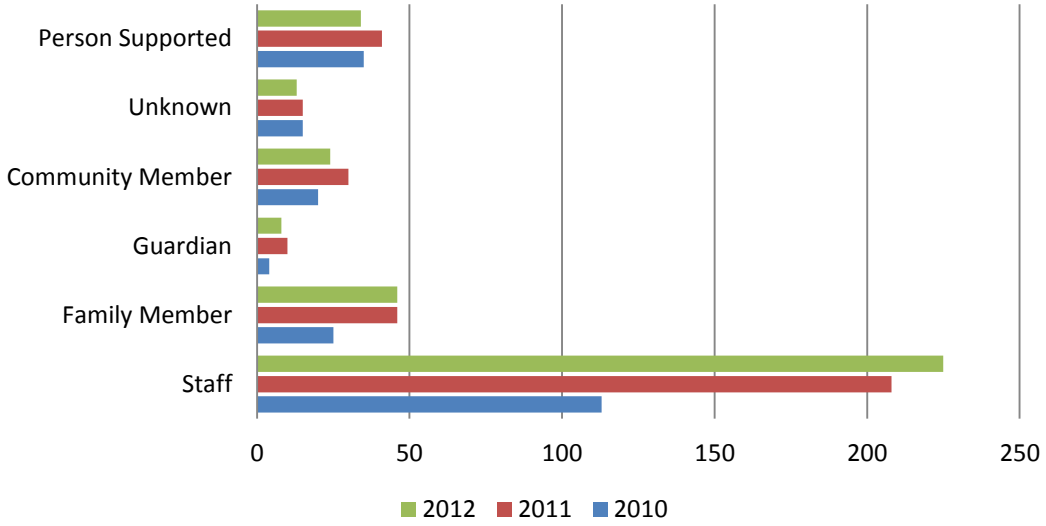


In 2007, specific data related to the number of each categories was collected, with additional data collection developed in 2008 for substantiation rates and in 2010 for abuse type and suspect. It is evident from the chart above that suspected abuse reporting has historically been higher than neglect and exploitation reporting.

It should be noted that the total highest reporting for all three categories was in 2007 and gradually decreased until 2011, when a slight increase occurred. This may be correlated with the fact that in 2007, three CSPs began a formal initiative in using Person Centered Thinking (PCT). In 2008, ten more providers began the same initiative and finally in 2009, four more providers began the formalized process. As the number of CSPs receiving ongoing support with the use of PCT increased, the number of allegations of ANE decreased.

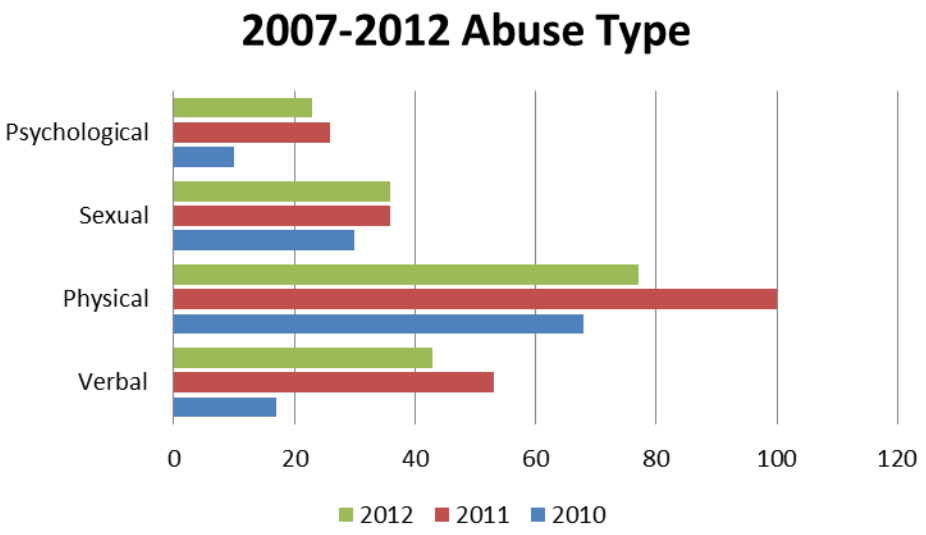
Other factors that may be attributed to the increase in 2011 is that previously altercations between people supported and staff/community members were reported in Victim of Altercations whereas now it is reported in ANE section of the reporting format. Also, in July 2011 mandatory reporting to either Adult Services and Aging, law enforcement or the State's Attorney General's Office was required, possibly increasing the reportable incidents.

2010-2012 Suspects of Abuse, Neglect and Exploitation

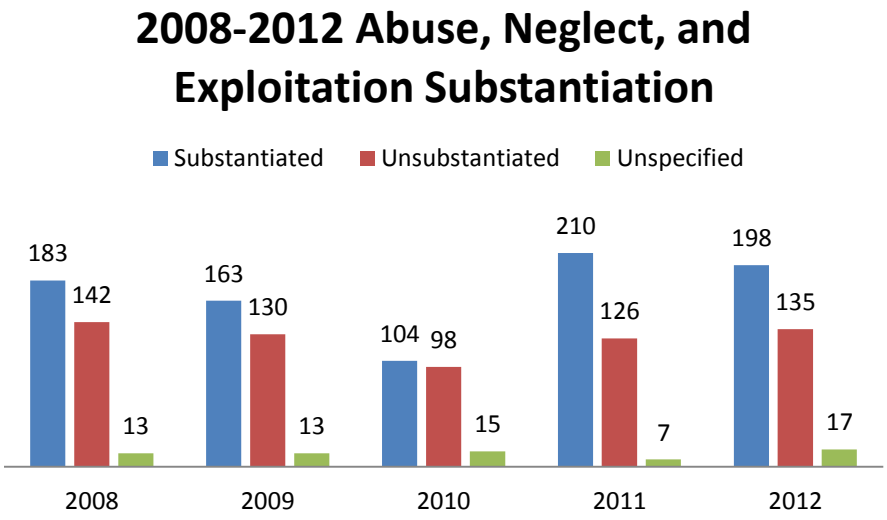


In 2012, incidents of ANE decreased by 16 incidents from 2011. The number of allegations against staff increased and family member allegations remained the same. Allegations against guardian, community member, person supported and unknown decreased. Incidents in which staff were accused of ANE totaled 225, an increase of 17 incidents from 2011. Allegations against community members decreased by six, allegations against guardians decreased by two, and other person supported decreased by seven. Family member allegations remained the same from 2011 to 2012 reporting 46 incidents.

From 2010-2011 the number of reported incidents increased in most categories. The reason for this could be attributed to the mandatory reporting codified law that was enacted in July of 2011. The DDD conducted a statewide training in November of 2011 which clarified that all allegations of abuse, neglect and exploitation are reportable to the DDD as an incident report. In addition, Department of Social Services partnered in this training to provide clarification of the reporting requirements of the newly enacted law on reporting abuse and neglect of disabled adults.



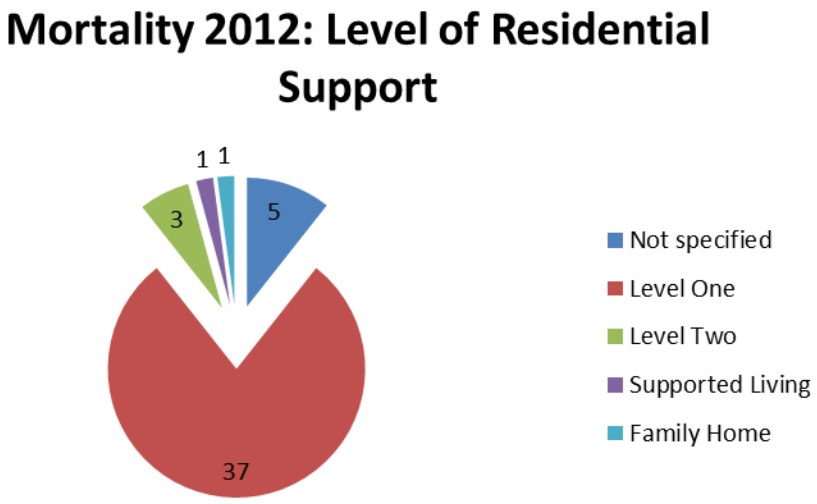
Decreased reporting occurred in all categories of abuse in 2012, with the exception of sexual abuse which remained the same from 2011. In 2012, allegations of psychological abuse decreased by three incidents, allegations of physical abuse decreased by 23 incidents, and verbal abuse decreased by 10 incidents.



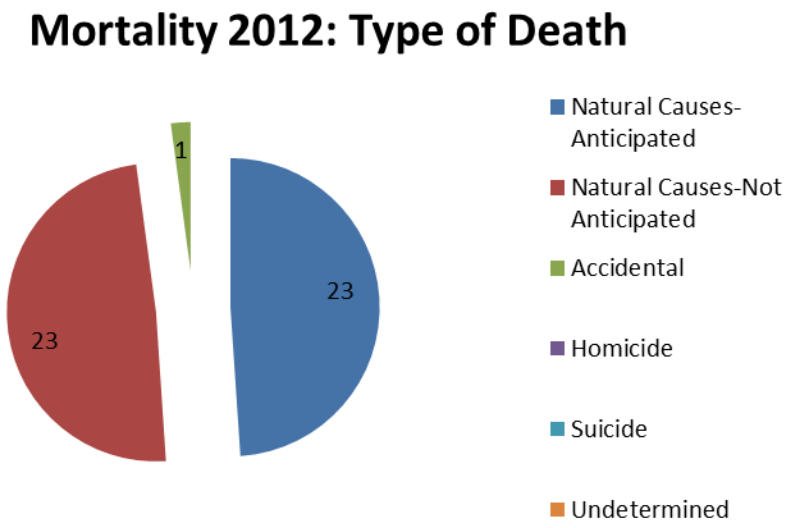
Since 2008, the trend of substantiation of ANE allegations has remained relatively consistent, with the lowest substantiation rate of 47% in 2010 and the highest substantiation rate of 61% in 2011. 2008 and 2009 substantiation rates were 54% and 53%, respectively. The DDD will continue to monitor these trends and provide technical assistance regarding investigations to providers as necessary. It is noted that data regarding substantiation begins in 2008, as this was when the DDD began collecting this information.

MORTALITY ANALYSIS: 2012

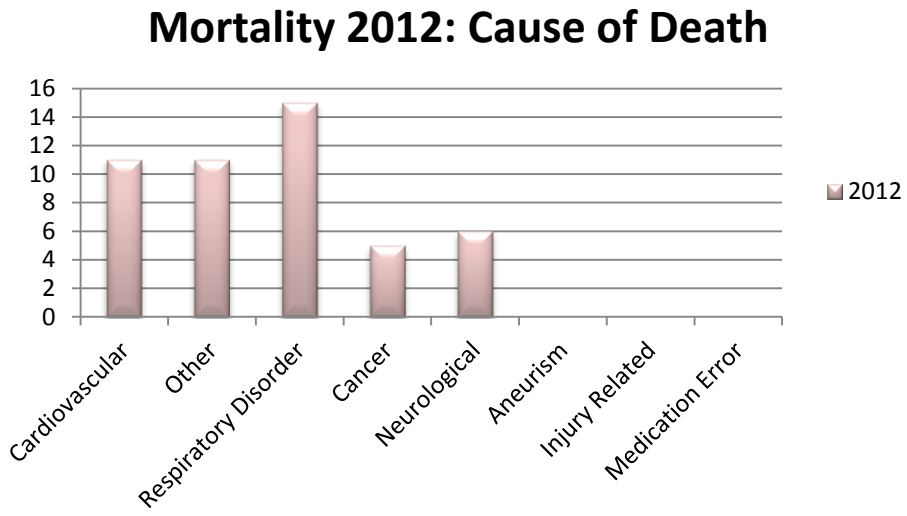
By definition, state developmental disability systems support people from an early age until death. Supporting individuals through the end stages of their life is a critical function that CSPs provide to participants. In South Dakota, the relatively low number of deaths each year makes it difficult to detect annual trends. The DDD reviews all deaths and may conduct investigations of any deaths that are accidental, unexplained, or occur amidst allegations of abuse or neglect.



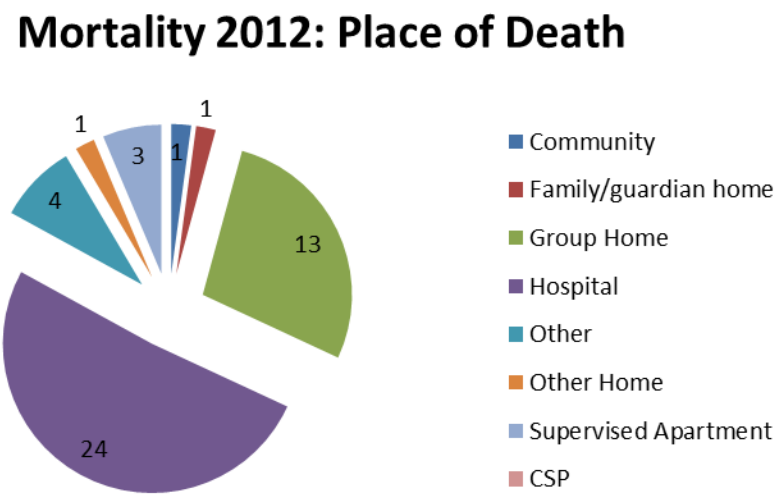
In 2012, there were 47 deaths of participants in CSP services. Of these, 37 participants were receiving residential supports in a Group Home setting, three in a supervised apartment, and one in supported living. Instances in which the level of supervision is "Not Specified," indicates that the participant did not receive residential supports from the CSP.



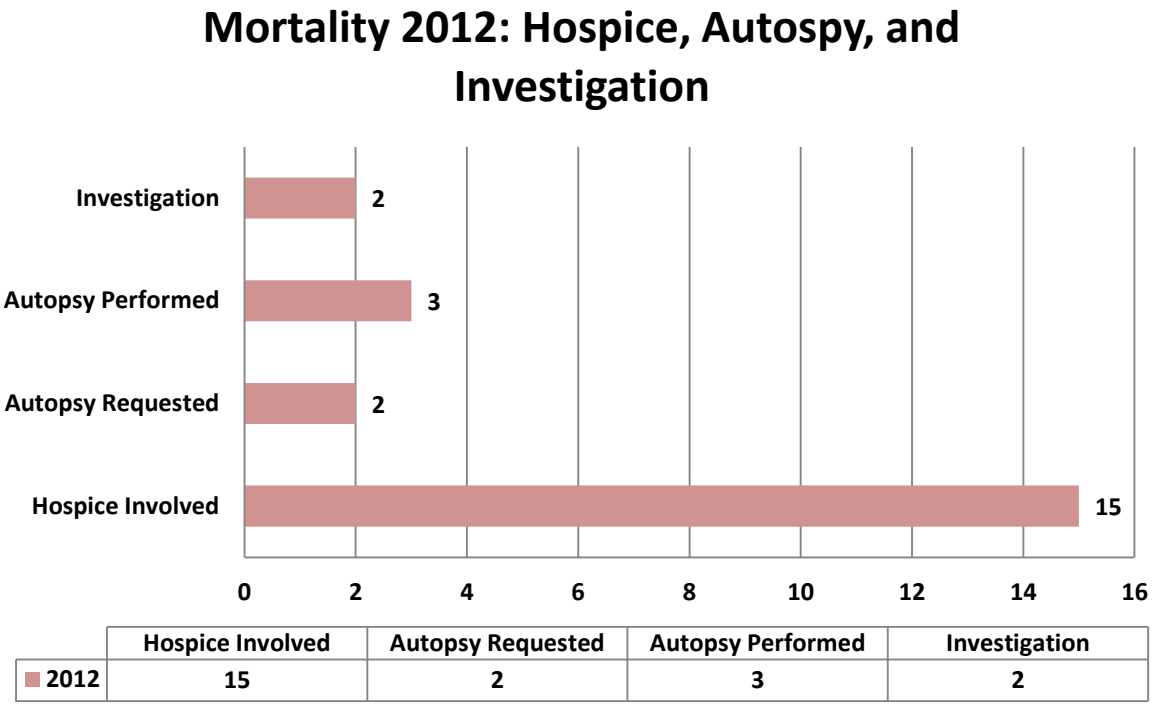
As seen in the graph above, 23 deaths in 2012 were due to natural causes that were not anticipated and natural causes that were anticipated, and one accidental death. The accidental death was a result of hypothermia, police department was involved and an investigation occurred. There were no homicides, undetermined deaths or suicides reported in 2012.



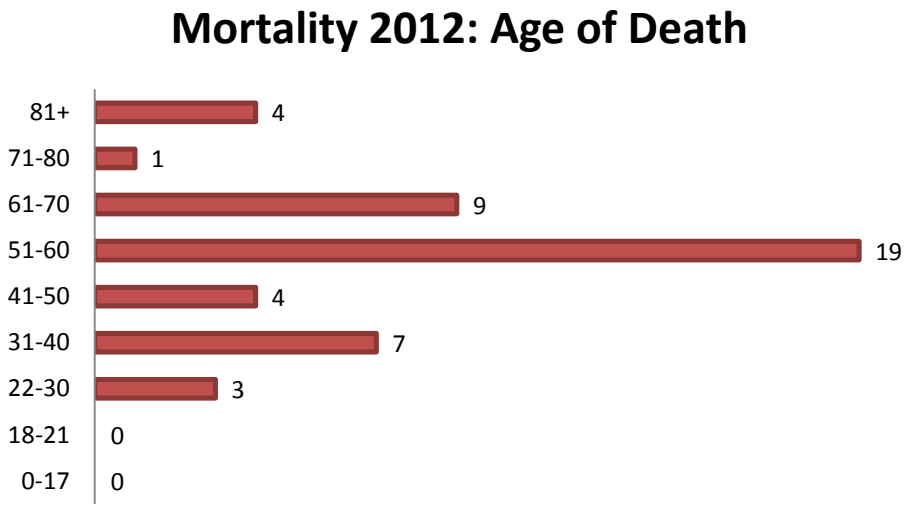
The leading causes of death in 2012 were Respiratory (15), Cardiovascular (11) and Other (11). Other category indicates that the cause of death did not fall into other available options within cause of death. Of the deaths reported as Other, two of these were categorized incorrectly and should have been captured in respiratory and neurological. The second and third leading causes are neurological and cancer, respectively. There were no deaths resulting from aneurism, injuries, or medication errors.



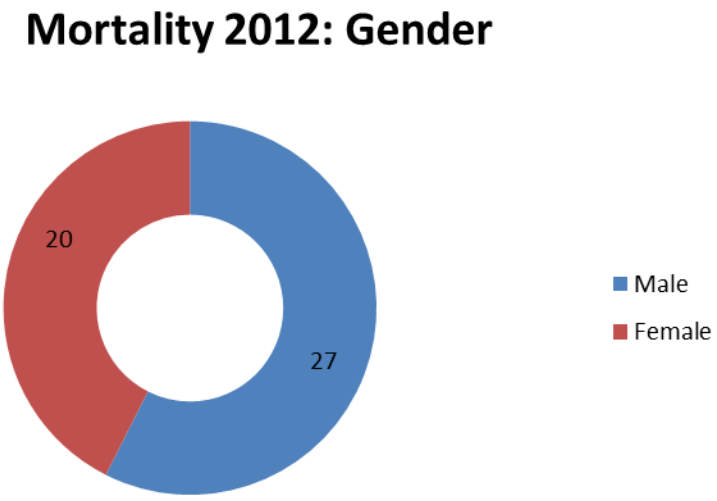
As the graph above demonstrates, 24 of the 47 incidents of death occurred at a hospital, while 13 occurred at a group home, four occurred in Other locations, and the remainder occurred either in the community, other home, supervised apartments or provider day program. Of the four deaths that were reported in an "Other" location, three occurred in a nursing home and one occurred in a hospice setting.



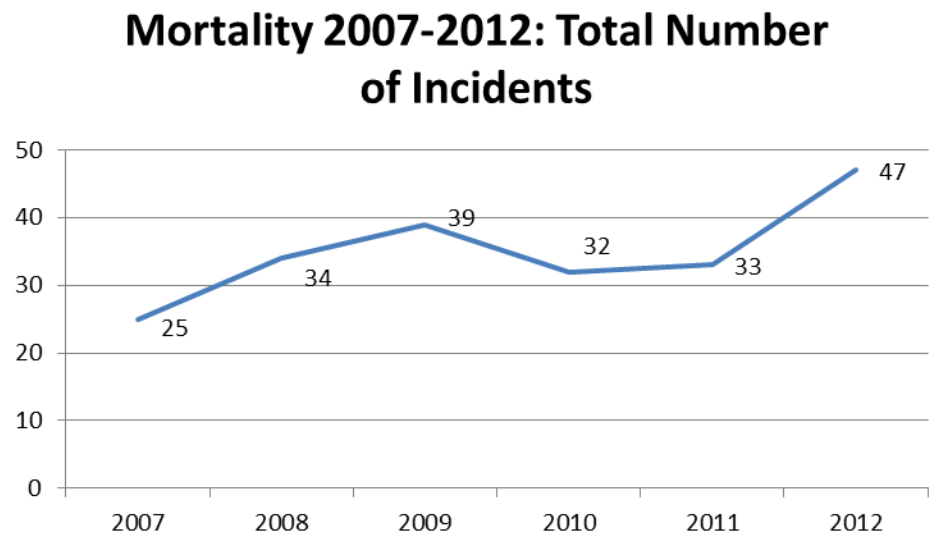
Of the 47 deaths that occurred in 2012, 22 of these were anticipated and hospice care was provided for 15 of the people. This demonstrates that providers are continuing to seek and utilize end of life care for participants.



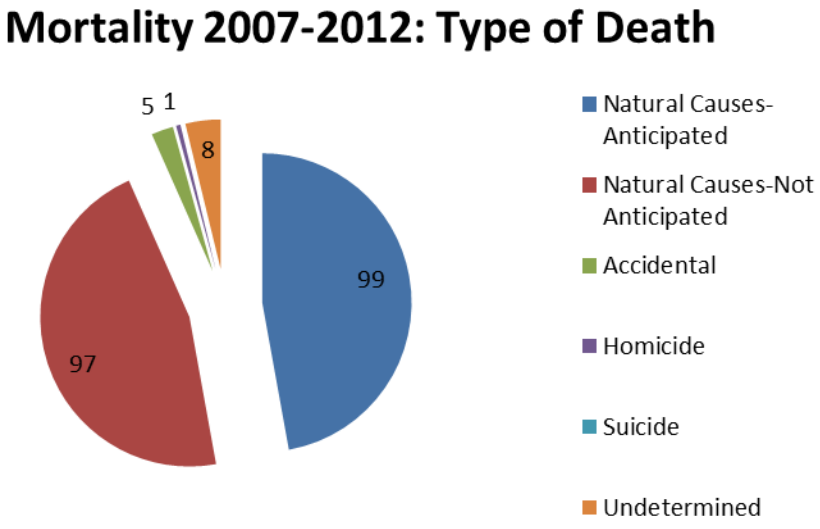
The graph above reflects the number of deaths in each age category. Nineteen participants in the 51-60 year old age range died in 2012, nine in 61-70, seven 31-40 and four in each of the age categories of 41-50 and over 81. Three deaths occurred in the 22-30 age range category and one participant in the 71-80 age range. There were no reported deaths for 0-17 and 18-21 age range categories.



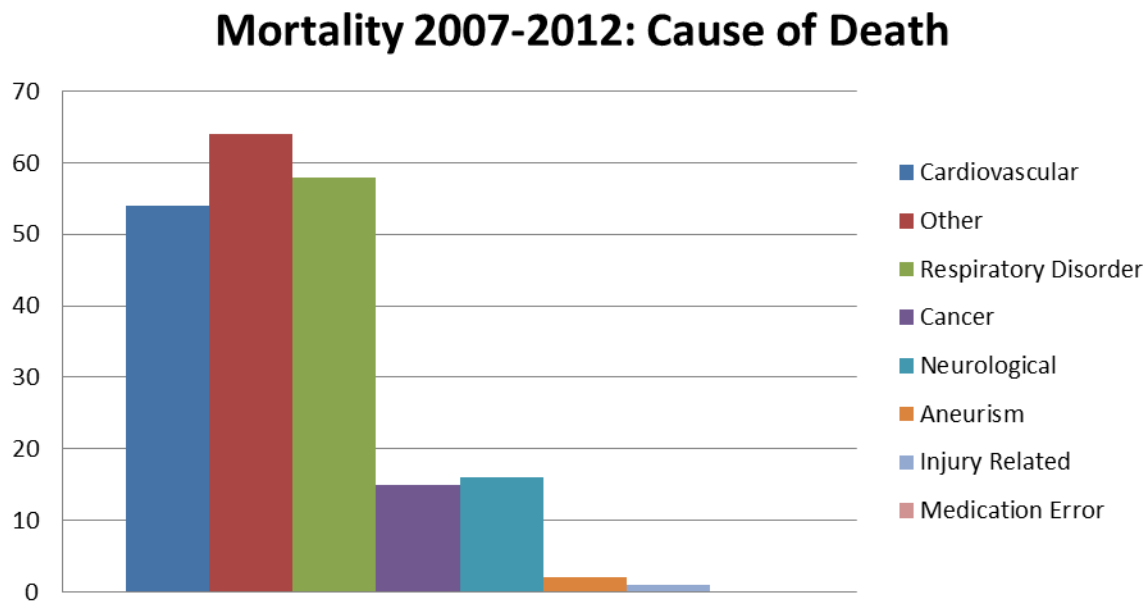
In 2012, 27 males and 20 females passed away. The percentage of males deceased in 2012 accounts for 57% of deaths; whereas the percentage of females accounts for 43% of deaths.



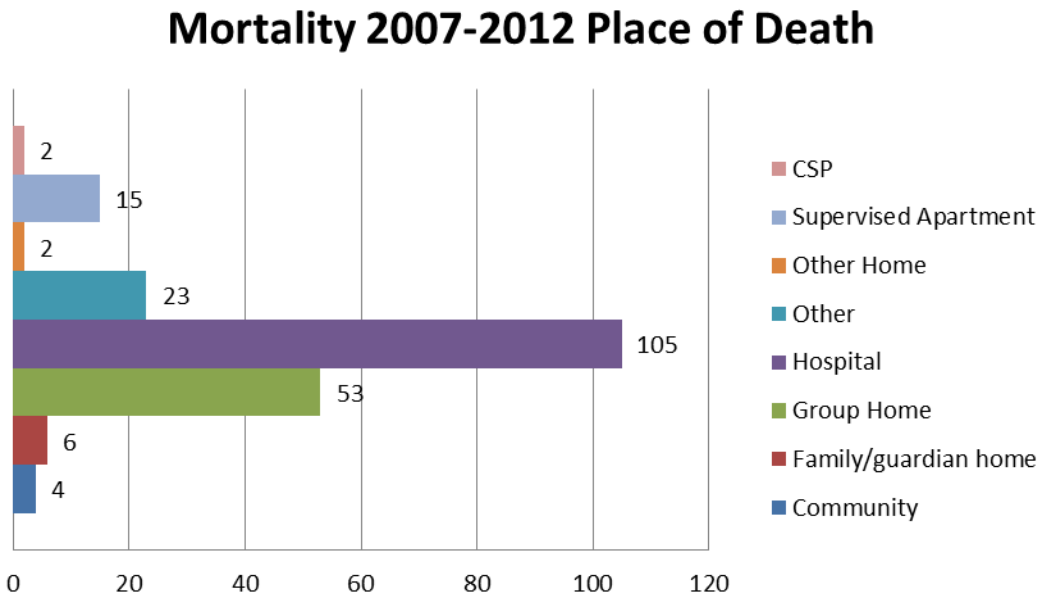
Over the course of the past six years, mortality rates have remained fairly stable. In 2010, the number of deaths decreased from the previous year, and has continued to increase since then. Forty-six of the deaths, in 2012, were from natural causes and one was an accidental death.



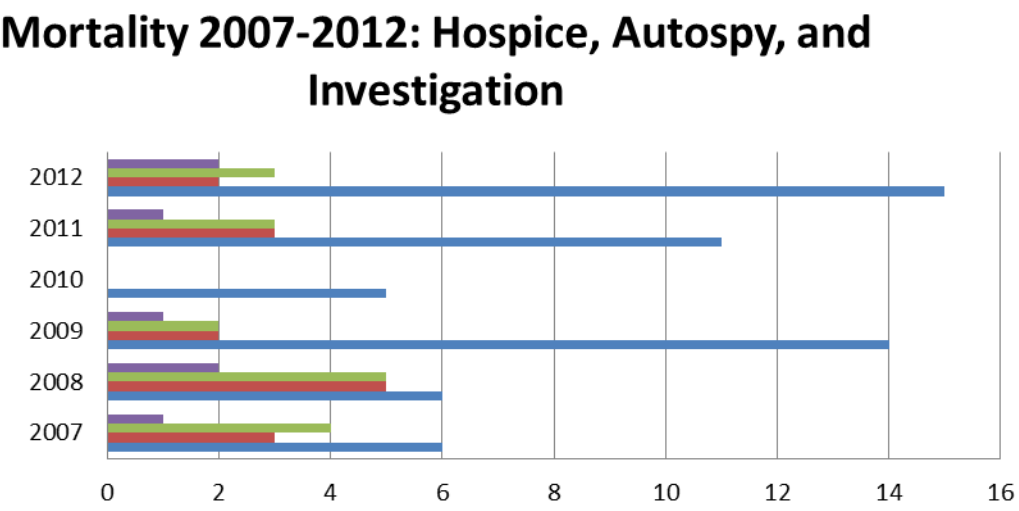
From 2007 through 2012, the leading type of death was natural causes-anticipated at 99, followed by natural causes-not anticipated at 97 deaths. Eight deaths were undetermined, five were accidental, and one was a homicide. The homicide occurred in 2008 when a participant and two community members were shot in a common area of their apartment building.



The leading cause of death from 2007-2012 is Other, followed by respiratory disorder and cardiovascular. The high number of Other deaths may indicate that the true cause of death should have been captured in the existing categories in the online report; however, analysis of the past two years has revealed the incorrect categorization of two incidents per year.

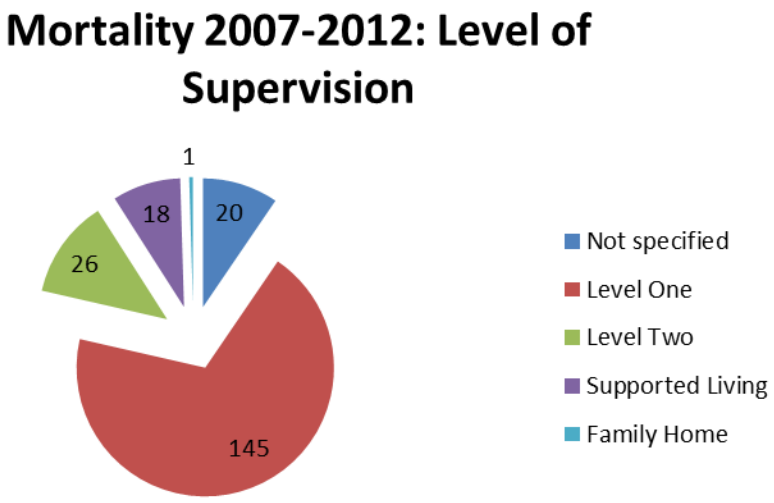


As the graph above demonstrates, 105 participants have passed away in hospitals, which is just over half of the total deaths reported. Fifty-three deaths occurred in group homes, and 23 occurred in "other" locations. This information is also consistent with the 2012 data, which means that these trends have been somewhat constant since 2007.

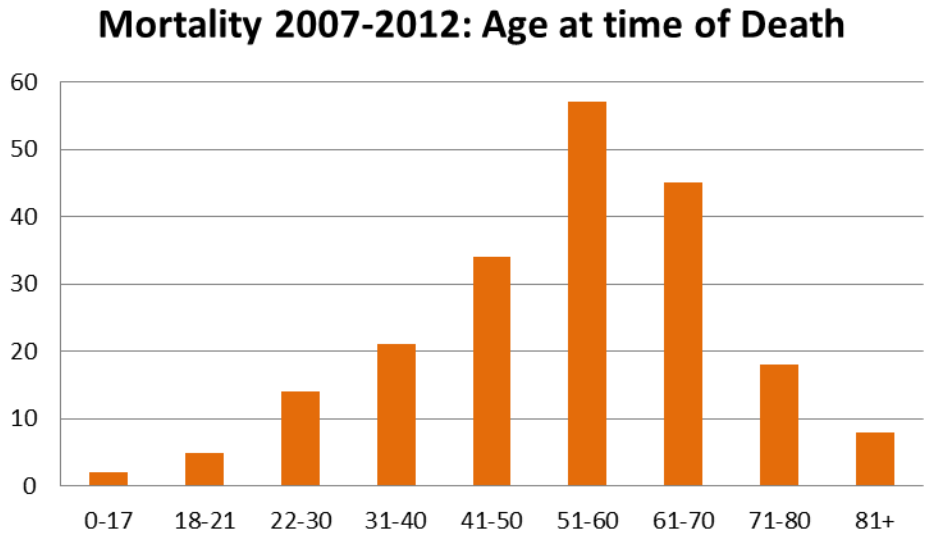


	2007	2008	2009	2010	2011	2012
Investigation	1	2	1	0	1	2
Autopsy Performed	4	5	2	0	3	3
Autopsy Requested	3	5	2	0	3	2
Hospice Involved	6	6	14	5	11	15

The graph above reflects actions taken prior to (hospice services) and after (autopsy, investigation) the death of a participant occurs. In 2009 there was a significant increase in the use of hospice, whereas the number of autopsies requested and performed remained relatively low. In 2012, one-third of participants who died had received hospice care. Considering that 22 deaths were anticipated, the data demonstrates that hospice use increased significantly since 2010. Providers should be commended for assisting participants in accessing hospice services which allow them to remain in their own home. The rate of death investigations has remained relatively steady, ranging between zero to two investigations per year. Investigations may be initiated and completed by a number of agencies including the provider, law enforcement, Medicaid Fraud Control Unit, Division of Developmental Disabilities, and/or the Department of Social Services.

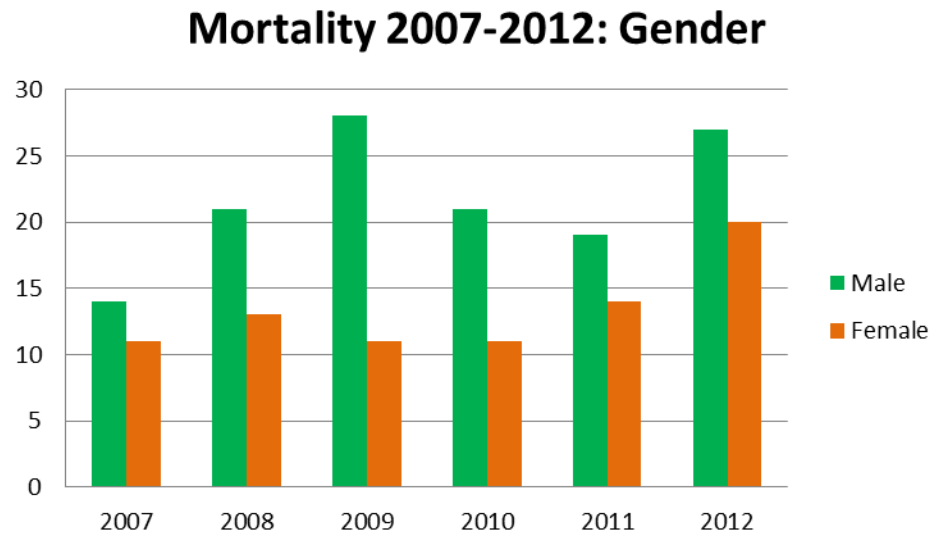


The graph and table above indicate that 145 of those who passed away were receiving Group Home residential supports at the time of their death, followed by Supervised Apartment supports, Not Specified and Supported Living. Again, if the level of supervision is "Not Specified," this is an indication that the participant did not receive residential supports from the provider.



Of the 210 deaths that occurred from 2007 through 2012, 57 of those participants were in the 51-60 age range, followed by 45 deaths in the 61-70 age range, then 34 deaths in the 41-50 age range. This may be due to the increase in aging population in community-based services. The age ranges with the lowest number of mortalities are 0-17, 18-21 and over 81, likely due to the participant population being the low system-wide in those age ranges. In 2012, the age range with the highest number of mortalities was 51-60, which is consistent with the overall data gathered from 2007-2011.

In the graph below, the gender mortality breakdown is found. The number of mortalities overall has remained somewhat stable, but it is noted that the number deaths is also somewhat consistent with the exception of 2007, in which there was a lower number of mortality reports.



SYSTEMS IMPROVEMENTS IN 2013

The CIR process is an important and continuous aspect of DDDs' quality management system. Thorough review of the data and substantive dialogue with a variety of stakeholders resulted in a number of planned systems improvements. One of the primary functions of this annual report is to provide interested parties with a summary of planned systems improvements. They are as follows:

1. CIR/QA Team will provide training and information to the Core Stakeholders group regarding current incident review practices and findings of the 2012 CIR Report. Input will be sought from the group regarding any recommendations for incident system improvement.
2. The DDD CHOICES waiver manager will share CIR data on a quarterly basis with the Internal Waiver Review Committee (IWRC), who will review and provide recommendations to the CIR/QA team and DDD Director;
3. CIR/QA Team will re-assess the determination of sample size for internal quarterly incident review;
4. CIR/QA Team identified the need to include "Hospital" into the dropdown options under Place of Death within Mortality Reporting which is currently in place;
5. CIR/QA Team monthly meetings will continue to include opportunity for DDD Program Specialists to inquire about a particular incident or trend in incidents, clarification of expectations, etc.;

6. Program Specialists will conduct technical assistance with providers as requested regarding clarification for CIR Guidelines and reporting expectations;
7. Training will occur on an ongoing basis for Program Specialists and provider staff to ensure reporting accuracy.

These improvements will increase the overall quality of the CIR process and the analysis capacity at both the state and provider levels.

Please direct any comments and questions about this report to Julie Hand, Program Specialist, at Julie.Hand@state.sd.us or Kelli Anderson, Program Specialist, at Kellij.Anderson@state.sd.us. Phone contact can be made with either Kelli or Julie at 605-773-3438.